



Neutral Citation Number: [2017] EWCA Civ 203

Case No: C1/2015/3208

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE ADMINISTRATIVE COURT
McGowan J
[2015] EWHC 2296 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/03/2017

Before:

THE LORD CHIEF JUSTICE OF ENGLAND AND WALES
LADY JUSTICE HALLETT
and
LORD JUSTICE UNDERHILL

Between:

The Queen on the Application of YZ	<u>Appellant</u>
- and -	
Oxleas NHS Foundation Trust & Anor	<u>Respondent</u>

Richard Gordon QC and Susanna Rickard (instructed by **Richard Charlton Solicitors**) for
the **Appellant**
Fenella Morris QC (instructed by **Capsticks LLP**) for the **1st Respondent**
Vikram Sachdeva QC (instructed by **Bevan Brittan**) for the **2nd Respondent**

Hearing dates: 12 & 13 December 2016

Approved Judgment

Lord Thomas of Cwmgiedd, CJ:

Introduction and summary

1. This case involves a challenge by way of judicial review to the decision made by a psychiatrist at the Oxleas NHS Foundation Trust (Oxleas), the first respondent, which operates a Medium Secure Unit for psychiatric patients in Dartford, Kent, to seek to transfer the claimant to Broadmoor Hospital (operated by the second respondent to whom I shall refer to as Broadmoor) and the decision of Broadmoor to accept him. Both decisions were made finally in March 2015.
2. The claimant was convicted on his guilty plea in April 2010 of an offence of causing grievous bodily harm committed when he was 15 years and 11 months on 17 March 2009 against a 12 year old boy. On 1 October 2010, he was sentenced to a hospital order with restrictions under ss.37 and 41 of the Mental Health Act 1983 (MHA 1983) on the basis that he suffered from complex mental health problems, including paranoid schizophrenia, emotionally unstable personality disorder and anti-social personality disorder.
3. He challenged the decision made to transfer him to Broadmoor on the basis that it was unlawful and in breach of his rights under the European Convention on Human Rights. He contended that he should have been transferred to a Medium Secure Unit.
4. An order for anonymity of the claimant was made by the first judge to consider the case. Despite the fact that there is a clear public interest in the public knowing how a person the subject of a hospital order with restrictions has been treated in the course of his sentence, there are issues relating to the claimant's transgender status which explain the making of the order after balancing the relevant considerations (as explained by the Supreme Court in *R(C) v Justice Secretary* [2016] 1 WLR 444). As the anonymity order in respect of the claimant has not been challenged by the respondent health trusts, I do not consider in the particular circumstances of this case that the court should set aside the order for anonymity of the claimant of its own motion. As raised at the hearing, there is no need to continue the anonymity order in respect of the trusts and the doctors of the hospital at which the claimant was treated.
5. The challenge to the decision to transfer came on for hearing by way of a rolled-up hearing for judicial review on 21 May and 2 June 2015. On 2 June 2015 the judge, McGowan J, refused permission, giving her reasons subsequently in a short but entirely persuasive and compelling judgment.
6. In consequence on 3 June 2015 the claimant was admitted to Broadmoor Hospital.
7. On 18 September 2015 following on from a further conviction in October 2014 for assault by beating and assault occasioning actual bodily harm, the claimant was made subject to a further hospital order under s.37/41 of the MHA 1983 which expressly placed him in Broadmoor.
8. The claimant applied for permission to appeal and/or permission for judicial review. Permission for judicial review was granted by the single Lord Justice on 14 January 2016. He held that the grounds as put before him were reasonably arguable and because the Administrative Court had refused permission following a "rolled up"

hearing, at which the substance of the claim was fully argued, special reasons existed for the proceedings to be retained in this court.

9. It is important to note that in the meantime the claimant remained at Broadmoor where he has been treated with a degree of success. Steps had been long in the making in arranging for his transfer for a trial period at a new Medium Secure Unit in the Midlands of England; he began that trial on the first day of the hearing before this court on 12 December 2016.
10. In these circumstances the further pursuit of these proceedings was entirely moot. However, despite the significant cost to court time and in fees to lawyers, we were told its continuation was justified. It was asserted that as the relief claimed before us was a declaration, it was important for others, who might suffer from transgender dysphoria, to have the decision of the court as to how anyone detained in a psychiatric hospital in circumstances similar to the claimant should be treated for the future.
11. The costs of these proceedings have been:
 - i) Claimant £65,000 (exclusive of VAT) funded by legal aid;
 - ii) Oxleas £58,318.08 (inclusive of VAT);
 - iii) Broadmoor £75,000 (inclusive of VAT).
12. I consider that these proceedings should never have been pursued before this court. I would dismiss them without hesitation for the reasons I will express. However, I do need to set out the facts in some detail to show how diligently the doctors and trusts concerned had tried to treat the claimant, how carefully they had taken the decisions and how wholly unjustified is the criticism to which they have been subjected. It is readily apparent that in such a case, the very substantial expenditure that the pursuit of this or similar claims entails, is a highly detrimental distraction to the proper operation of the National Health Service and has caused the expenditure of substantial sums which could and should have been used instead for the treatment of patients.
13. As these were proceedings brought through legal aid, the Chief Executive of the Legal Aid Agency should ensure for the future that the Agency carefully examines the circumstances in which the Agency allows such cases to be pursued, particularly to this court, given the very significant costs that the NHS incurs as a result, quite apart from the need carefully to use the small resources that Parliament has made available for legal aid. We direct that a copy of this judgment be sent to the Chief Executive.

The factual background

The claimant's early years and his criminal conviction

14. The claimant was born female in the first quarter of 1993 in London and initially grew up in South East London. He had a difficult childhood with periods in care and suffered from bullying and other abuse. In March 2009 he inflicted grievous bodily harm with intent to a 12 year old victim; he attacked him with a brick rendering him unconscious and leaving his body covered with leaves. The victim required facial reconstruction surgery. The claimant committed a further serious offence against a

girlfriend, punching her, smashing a patio door and chasing her down a road whilst he threatened her with a knife.

15. In August 2009, he was admitted to secure accommodation under s. 25 of the Children Act 1989. On 13 November 2009 he was admitted to the Rycroft Unit at St Nicholas Hospital in Newcastle under the care of Dr Alison Westman, a consultant child and adolescent psychiatrist.
16. On 23 April 2010 he pleaded guilty in relation to the offence of causing grievous bodily harm with intent to the boy he had attacked with a brick. On 1 October 2010 at the Crown Court at Newcastle the hospital order under s.37/41 was made because of his complex mental health problems including paranoid schizophrenia, emotionally unstable personality disorder and anti-social personality disorder.
17. In 2010 he was diagnosed as having, in addition to complex mental health problems, gender dysphoria. Specialist advice was taken and he was supported in his desire to live his life as a man. In mid-October 2010 the claimant adopted his new name and life as a man.
18. It is evident from a detailed report by Dr Alison Westman dated 24 April 2012 that he continued to pose a significant risk of harm to others and continued to show a range of aggressive and violent behaviours to staff and other patients resulting in significant injuries to staff. The report stated he had been referred to the Gender Dysphoria Service at the Charing Cross Hospital, London.

The transfer to the Bracton Centre

19. As the claimant was the responsibility of the Greenwich PCT he was referred to the Bracton Centre, a Medium Secure Unit, operated by Oxleas in Dartford in Kent in anticipation of his transfer there when an adult. There was some consideration as to whether he should be admitted to a male or a female adult forensic service, but in the light of advice taken by Oxleas under the Gender Recognition Act 2004, the claimant was transferred at his request to the male adult service.
20. He was assessed at the Rycroft Clinic, Newcastle by Dr Anhoury, a consultant forensic psychiatrist at the Bracton Centre on 26 April 2012. She was told of the instances of aggression by the claimant at the Rycroft clinic to which Dr Westman's Report had referred as I have set out; there had been none since the beginning of 2012. It was agreed he should undergo a trial period at the Bracton Centre.
21. On 4 June 2012 the claimant and another inpatient refused to leave a courtyard at the St Nicholas specialist unit, the Rycroft Clinic, after being requested to do so by staff and then threatened to harm staff if the response team was called. The claimant and his fellow inpatient then caused damage to the courtyard and used broken glass to threaten staff and to self-harm. The police, armed with tasers, had to be called.
22. With the consent of the Secretary of State for Justice, the claimant was given a trial period at the Bracton Centre between 6 and 8 June 2012. However, the Bracton Centre were not advised of the serious incident that occurred on 4 June 2012 at the Rycroft Clinic.

23. The trial was successful, but before making the transfer to the Bracton Centre from Newcastle, Dr Anhoury took the opinion of the admissions panel at Broadmoor on 11 June 2012 as to whether the claimant required transfer to Broadmoor for its high security, given the serious incident on 4 June 2012 at the Rycroft Clinic. Her report to Broadmoor pointed out that the claimant had yet to receive any form of treatment for his gender reassignment, but he had expressed a wish to proceed with this treatment and had been referred to the Gender Service at the Charing Cross and Westminster Hospital.
24. The admissions panel at Broadmoor, after a report from a consultant forensic psychiatrist who assessed the claimant at the Rycroft Clinic on 18 June 2012, determined on 28 June 2012 that he did not meet the threshold for admission to high security, but could be managed in a Medium Secure Unit. He therefore was transferred from the Rycroft Clinic in Newcastle to the Bracton Centre on 18 July 2012 under the care of Dr Anhoury, as the Responsible Clinician.
25. On 24 April 2013 Dr Anhoury referred the claimant to the Charing Cross Gender Identity Clinic. He was not seen until 23 December 2013.

Second consideration of a transfer to Broadmoor: October 2013-March 2014

26. In the intervening period between April 2013 and December 2013 the claimant reported that male residents had made sexual advances to him. However, much more significant was a serious incident on 28 September 2013 when the claimant kicked another patient and was alleged to have tried to suffocate him with a pillow and strangle him with a ligature. Another psychiatrist at the Bracton Centre, acting on behalf of Dr Anhoury, who was on leave, sought advice for a second time from Broadmoor as to whether he should be admitted. The history of the claimant's admission at the Bracton Centre was reviewed by a specialist registrar at Broadmoor under the supervision of Dr Callum Ross, a consultant forensic psychiatrist at Broadmoor. The report dated 21 October 2013 records a conversation with Dr Anhoury in relation to the claimant's gender dysphoria:

“In relation to his gender issues, she informed me that [the claimant] had not had any formal assessments in relation to gender reassignment. She explained that the specialist at Charing Cross Gender Identity Clinic had a special interest in forensic issues and the team had referred him to the service earlier this year with the aim of an initial assessment. She said that the clinical team's view had been that the main aim of his treatment at the Bracton Centre was to treat his mental disorder and address his violent risk, which had been explained to the claimant. She said that she had informed [the claimant] that any treatment related to his gender reassignment would be more appropriate in the future when he was more stable and progressing well. She explained that in recent weeks she had informed him that the average age of people having gender reassignment surgery was late 30s. She also mentioned that in his case there was a risk that sexual themes could trigger violence.”

The report recommended admission of the claimant to Broadmoor as he could be more safely managed in the environment of a high security setting. It was recognised in the report that his specialist needs relating to his sexual identity issues and related risks to him and others might be more assertively and safely managed in the high security setting. On 7 November 2013 the Broadmoor admissions panel agreed to his admission, subject to a meeting between professionals. That meeting duly took place. It was agreed that it would be helpful to have the opinion of the gender identity clinic.

27. Dr Ahmad, a consultant psychiatrist and psychosexual therapist at the Charing Cross Clinic, therefore examined the claimant on 23 December 2013 in connection with the proposed transfer to Broadmoor. He recommended in his report made that same date but not typed until 6 January 2014 that the claimant should have his care managed in a male unit, that he needed to make a transition to clozapine and to stop using illicit substances, and should have an assessment in due course by his colleague Dr James Barrett at the Gender Identity Clinic at the Charing Cross Hospital. The letter stated:

“I was clear with [the claimant] that this treatment would only happen in the context of some stability in his mental state and his behaviour.”

28. On 25 February 2014 Dr Clare Dillon, a consultant psychiatrist at Broadmoor, who was asked to re-assess the claimant for admission to Broadmoor because of the delay, interviewed the claimant on 5 February 2014, after a review of his intervening history, and concluded against his admission to Broadmoor. Her report noted that the Bracton Centre had been able to contain the risk of serious violence in the period after September 2013, despite some violent incidents and assaults on staff, after 1:1 observation and treatment with Risperdal depot. After a further incident he had been treated since 5 February 2014 with clozapine which Dr Dillon supported. The report recognised that caring for someone with a complex personality structure such as the claimant was difficult, but robust supervision should be capable of dealing with this. She considered that a transfer to high security could be detrimental to the claimant; she noted that the gender identity clinic had expressed some concern over the 2:1 observation he would require at Broadmoor, although they had not explained the basis of the concern.
29. On 6 March 2014 the panel at Broadmoor accepted the view of Dr Clare Dillon that the claimant’s current clinical presentation did not support admission to high security in terms of immediate and grave risk. The panel would reassess him urgently if there was a deterioration.

Treatment at the Bracton Centre in 2014: clozapine

30. In the summer of 2014 appointments for the attendance of the claimant at the gender identity clinic did not take place due to diary and administrative errors.
31. In September 2014 the claimant instructed Richard Charlton Solicitors in connection with a planned application to the First Tier Tribunal. In the letter the solicitor set out the claimant’s contention that his refusal to take clozapine and his other behaviours had been driven because he had not been to an appointment at the gender identity clinic.

32. During the course of October 2014 he did not take clozapine for periods of a week or more. On 21 October 2014 the claimant absconded. On 22 October 2014 he assaulted another patient. His behaviour in the period between May and November was summarised on 4 November 2014 as the claimant “having had a tumultuous time over that period”. He had intermittently stopped taking clozapine, self-harmed, taken cannabis, absconded from the unit and assaulted another patient. It was thought that this had been in response to stressors such as missing his gender clinic appointment, members of staff with whom he had developed strong attachments leaving and a recent influx of new residents to the clinic.
33. Matters deteriorated during the course of November 2014. He refused to take clozapine; he was recommended to have a depot injection but refused; there were incidents in which he made weapons, although he handed them over.
34. As the judge pointed out, clozapine has to be taken regularly, consistently and for a significant period of time if it is to be an effective anti-psychotic drug. It was the claimant’s case that it was causing unpleasant side effects, but it is not a drug that can be stopped and started.
35. On 28 November 2014 Dr Anhoury wrote to the gender identity clinic asking for a further appointment.

The claimants’ further conviction

36. On 31 October 2014, the claimant pleaded guilty at Maidstone Crown Court to assault by beating and assault occasioning actual bodily harm to a patient on 28 September 2013. The papers show that he assaulted a patient with a plastic bottle, tried to suffocate him with a pillow and then tried to strangle him with a piece of cord. As I set out in more detail at paragraph 69 below a further hospital order was made on 18 September 2015 under s.37/ s.41 of the MHA 1983. From June 2014, he was assessed by Dr Andrew Iles. Only one of his reports obtained on behalf of the claimant by his solicitors in the criminal proceedings was made available to us as I set out at paragraph 69.

Third request to Broadmoor

37. On 4 December 2014 Dr Anhoury’s assistant wrote to Broadmoor asking for a third assessment of the claimant for high security. The letter set out details of the current events and stated that the team was very concerned with the claimant’s behaviour and presentation and thought that he was becoming unmanageable within conditions of medium security. On 14 December 2014, he was placed in the Intensive Care Ward at the Bracton Centre as a result of a further assault on a nurse.
38. On 12 December 2014, Richard Charlton Solicitors informed the admissions panel at Broadmoor that they wished to make representations. They complained to the panel and Dr Anhoury about the failure to mention the claimant’s gender dysphoria in the report sent by the Bracton Centre. A representative of these solicitors visited the claimant on 18 December 2014 when he was detained in the Intensive Care Ward. The following day they complained to Dr Anhoury about the conditions in which the claimant was being held, describing them as “punitive and threatening”. I have seen no evidence which in any way justified such a description of the conditions in which

the claimant was being treated. The solicitors stated they were drafting a letter of complaint.

39. It is clear from a record from a doctor appointed to give a second opinion that in early January 2015 the clinical team wished to stabilise the claimant's mental state using depot anti-psychotic before reinstating clozapine.
40. A report for the First Tier Tribunal made on 5 January 2015 recorded the claimant was still being treated in the Intensive Care Ward where he had caused damage to property. His compliance with his treatment programme was sporadic. He was becoming unmanageable under conditions of medium security.

The complaint made on behalf of the claimant: January 2015

41. On 9 January 2015, Richard Charlton Solicitors wrote, as they had indicated on 19 December 2014, a letter of formal complaint to the Chief Executive of Oxleas. It ran to some 10 pages. In summary, it complained about the failure to afford him proper treatment, the failure to deal with his gender dysphoria, various allegations of breach of confidentiality, harassment and bullying by staff members and making a specific complaint about his treatment by Dr Anhoury. The letter stated that the solicitors considered it inappropriate for the claimant to remain under the care of Dr Anhoury as his responsible clinician. The letter stated that the decision to refer to the Admissions Panel at Broadmoor was "irrational, unreasonable and punitive"
42. Although the evidence indicates that the relationship between the claimant and Dr Anhoury had broken down, I wish, however, to make it clear that on the evidence before us no criticism of Dr Anhoury is in any way justified; she did her utmost to care for the claimant with a high degree of professionalism. Nor on the evidence before us is there any substance in the other complaints made. Nor could the statement that it was "irrational, unreasonable and punitive" to refer the claimant to the Admissions Panel at Broadmoor be in any way justified on the evidence before us. The way in which the claimants' complaints were advanced, in my view, showed a distinct lack of the professional objectivity I would have expected from a responsible firm of solicitors.
43. Dr Paul Monks, consultant psychiatrist at the Bracton Centre, was appointed as the responsible clinician. He had become a consultant in 2003 and had spent 6 years working with young adults and adolescents. He agreed with the diagnosis of emotionally unstable and dissocial personality disorder, transient psychotic symptoms and gender dysphoria that had been made.
44. Dr Clare Dillon who had assessed the claimant on 19 December 2014 in connection with the proposed transfer to Broadmoor provided a report dated 16 January 2015. She concluded that forming an opinion about the level of security required to manage the risk posed by the claimant was more difficult than her previous assessment; the fact of his having homemade weapons and his escape from medium security made matters very serious. The chronicity of his threats and physical aggression had increased. Nonetheless on balance she had formed the view that the behaviours did not meet the threshold for admission to Broadmoor. The relationship with the treating team and the Bracton Centre had broken down. She recommended an alternative

medium secure placement should be found. If the claimant was to be transferred to Broadmoor, he would need 2:1 observations.

45. Richard Charlton Solicitors instructed Dr Charlotte Page, at the time a consultant to the *Kids Company* charity and a medical member of Mental Health Review Tribunals since 1993, to make a report on the claimant. She saw him on 30 January 2015. Her report dated 2 February 2015 was enclosed with representations to the Broadmoor Admissions Panel contending that the claimant failed to meet the standard required for admission to Broadmoor. She expressed the view that the admission to Broadmoor was neither necessary nor desirable and he could be treated at the Bracton Centre “where he is settled and poses no management problem”, though he would need a long-term placement elsewhere. He needed urgent treatment at the Gender Clinic. No criticism was made of his care at the Bracton Centre. The incidents to which I have referred were said by Richard Charlton Solicitors to have arisen as a result of Oxleas’ “generally inadequate treatment of [the claimant’s] diagnosis of gender dysphoria, coupled with their frequent, and often serious failure to safeguard him.”

The decision to admit to Broadmoor and the decision of the Broadmoor Appeal Panel

46. On 12 February 2015, the Broadmoor panel decided by a majority that, if he was not taking clozapine, they should offer the claimant a bed. The letter of 19 February 2015 communicating this decision stated:

The panel took the view that the criteria for admission to Broadmoor Hospital relate solely to the issue of risk of harm to others. Any complications or challenges that might be involved in providing care for a transgender patient are not an issue that is germane to the criteria for admission and for the purposes of that decision we set that issue aside

47. The letter set out powerful and compelling reasons for the decision. The letter suggested as an alternative his resuming clozapine and being transferred to another Medium Secure Unit.
48. On 23 February 2015, Dr Monks accepted the offer stating it should be taken up as soon as possible in view of the deterioration of the claimant over the last two weeks.
49. The claimant decided to appeal to the Appeal Panel at Broadmoor. Dr Page was instructed to prepare a further report. She visited him on 4 March 2015 and prepared a further report setting out her view that the claimant was suffering from schizophrenia and setting out again her view that he did not need to go to Broadmoor. She expressed the view that he should be treated with clozapine and other measures. The claimant expressed a willingness to take clozapine.
50. It was contended by Richard Charlton Solicitors that the claimant’s willingness to take clozapine was new information and therefore the panel should consider the matter afresh rather than the matter being referred to an Appeal Panel. This contention was rejected by the chairman of the panel and an Appeal Panel was convened.
51. Submissions were made by Richard Charlton Solicitors to the Appeal Panel at Broadmoor which met on 27 March 2015. The panel unanimously concluded that the

claimant presented a significant risk to others that did meet the threshold for admission. It set out its reasons in a succinct, but very clear, form in a letter dated 27 March 2015 from the clinical director of Broadmoor. Included in the reasons was the following passage:

“the risk is both chronic and acute and includes the risk of manufacturing or using weapons, a history of absconding, a risk of fire setting, a risk to children and a risk of subverting security. These risks were considered to be directly associated with [the claimant]’s mental disorder and possibly exacerbated by the use of substances.

The panel concluded that, given [the claimant] has been prescribed clozapine on three previous occasions and has felt unable to continue taking it, his expression of willingness to comply with clozapine (following the response of the admission panel) is likely to be impacted upon by the prospect of admission to Broadmoor and therefore unlikely to be associated with sustained compliance...

The panel did not think that transferring [the claimant] to another medium secure unit would be appropriate at this stage, given the seriousness of his risks and in view of the future stress of his pending court appearance.

It was made clear that admission would not preclude his continued treatment of gender dysphoria and set out the objectives of his treatment at Broadmoor.

52. On 23 March 2015, Dr Monks set out compelling reasons why he would not treat the claimant with clozapine.
53. On 30 March 2015, the claimant had a further consultation at the Gender Identity Clinic with Dr Barrett. In his report to the Bracton Unit (sent on 12 June 2015 after the hearing before the judge) he stated:

... there seems little doubt that [the claimant] presents with a disorder of gender identity which is probably primary in nature of the issue has been complicated however by what appears to be a fairly clear cut- coincidental psychiatric illness and further longstanding poor impulse control

He also provided a report dated 15 April 2015 in answer to specific questions from Richard Charlton Solicitors.

54. The claimant’s behaviour which I have set out continued during April and May.
- i) On 31 March 2015, he self-harmed with a piece of glass; other incident of self-harm were frequent.
 - ii) He continued to threaten staff and to damage equipment at the Bracton Centre. On 1 May 2015, he punched a member of the staff as he entered the ward. On 3 May 2015, he started throwing chairs and tried to hit a member of the staff

- iii) On the night of 7 May 2015 he attacked a member of staff and rendered him unconscious and in need of immediate general hospital care.

The application for judicial review

- 55. Pre-action letters were sent on behalf of the claimant on 2 April 2015.
- 56. On 6 May 2015, a final decision was made to transfer the claimant to Broadmoor as accommodation was available.
- 57. On 8 May 2015 the claimant issued the application for judicial review. The application was ordered to be heard by way of rolled-up hearing and expedited. The relief claimed included:
 - i) The quashing of the decision of the panel at Broadmoor and a declaration that the constitution of the panel was unlawful
 - ii) A declaration that the transfer to Broadmoor would be unlawful.

An injunction against the transfer was sought.

The decision of the judge

The operative statutory provisions

- 58. The claimant's detention was governed by the provisions of s.37/41 of the MHA 1983; his transfer to another hospital was governed by s.19 of the MHA 1983 and regulation 7 of the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008. It was subject to the consent of the Secretary of State for Justice and the consent of NHS England which has to provide the funding.
- 59. A Code of Practice (the Code) under s.118 of the MHA 1983 was issued by the Secretary of State; the case proceeded on the version issued on 15 January 2015 which came into effect on 1 April 2015. The guiding principles are set out and explained in Chapter 1 of the Code; in respect of the principle of the least restrictive option, the Code requires that:

1.4 if the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available
...

1.5 any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action.

14. 3 Professionals must consider available alternatives, having regard to all the relevant circumstances, to identify the least restrictive way of best achieving the proposed assessment or treatment.

The basis of the claimant's claim before the judge

60. It was alleged that:
- i) The defendants had failed to have regard to paragraph 23.9 and 23.11 of the Code in that the defendants had failed to have regard to all the circumstances; they had failed to take into account the claimant's Convention rights under Articles 3 and 8; the decision was not simply one of clinical judgment. The court had to subject the decision to intense scrutiny and determine whether the decision to transfer was correct.
 - ii) Although the relationship with the staff at Bracton had again broken down, this was not a reason to transfer him to Broadmoor. He should be transferred to another Medium Secure Unit.
 - iii) The refusal to prescribe clozapine was irrational; the drug was available and should have been prescribed as the claimant wished to take it, being fully aware of the unpleasant side effects to which I have referred.
 - iv) His gender dysphoria was not being properly treated; as there was a link between his gender dysphoria and his mental health, it was the fault of Oxleas not to have expedited the treatment. A particular complaint was made of the delay in referring him to Gender Identity Clinic from his arrival at the Bracton Centre on 18 July 2012 until he was seen in December 2013 as I have set out at paragraph 25. This failure should be rectified instead of transferring him to Broadmoor.
 - v) The procedure at Broadmoor adopted had been unfair in that the decision to convene the Appeal Panel was contrary to the provisions of paragraph 14.2 of Policy A6. It was said that the matter should have been referred back to the Admissions Panel who were familiar with the claimant's case and he had therefore been denied the opportunity to appeal. It was also said that the decision was unlawful as the admissions criteria had not been followed, the reasoning was insufficient and relevant considerations had not been taken into account.

The judge's decision given on 31 July 2015

61. In addition to the documents evidencing the long clinical history which I have set out, there were statements from the claimant and from Dr Monks explaining why he would not treat with clozapine and why the transfer was necessary. There were medical reports from Dr Celia Taylor, lead consultant psychiatrist at North East London Forensic Personality Disorder Service, dated 15 April 2015 and a further report from Dr Charlotte Page dated 16 April 2015.
62. There was also a statement by Professor Stephen Whittle, professor of Equalities Law at Manchester Metropolitan University; although helpful in providing background on transgender issues, it was of no relevance at all to the issues before the judge as he had no medical qualifications. The same observations must be made in respect of the statements of Ruth Hunt and Terry Reed.

63. It was clear on the evidence before the judge that:
- i) Dr Monks, the claimant's responsible clinician, considered treatment with clozapine was inappropriate; no other clinician was prepared so to treat the claimant.
 - ii) The Bracton centre was unable to manage the claimant safely; he continued to threaten staff and had knocked a nurse unconscious.
 - iii) No other Medium Secure Unit would have been appropriate, given the severe risk of violence he posed.
 - iv) All relevant factors had been fully considered by Oxleas and Broadmoor before deciding to make the transfer.
64. On the basis of that clear evidence, the judge held that the decisions by Oxleas were entirely lawful; the decision not to prescribe clozapine was one that the responsible clinician was entitled to take; there were ample grounds for his decision. It was no longer appropriate to detain the claimant in conditions of medium security at Bracton. No other Medium Secure Unit would be willing to take him. The decision to seek a transfer had been carefully taken by Oxleas. The judge concluded:

[Broadmoor] will detain him in circumstances which balance the least amount of restriction necessary with such measures required for his own safety and that of the other patients, staff and the public in general. There is nothing which comes close to creating any risk to his Article 3 rights.

There is no basis upon which a judicial review of the decisions taken by [Oxleas] could succeed. The claim is forensically hopeless.

65. As regards the decision of the Appeal Panel of Broadmoor, the judge held that the reasoning of the panel was clear and entirely rational; it was not susceptible to judicial review. The process adopted was one that was proper. There was no new material to cause a reference to the panel.

The grounds of appeal

66. It was contended in the grounds of appeal that the decision to transfer did not meet the requirements of Article 8 and the principle of the least restrictive treatment in the MHA 1983. The judge had not performed a review of sufficient intensity. Her decision that there was no alternative Medium Secure Unit was perverse. The judge had failed to consider the issue under Article 3. The judge was wrong in her conclusion that the reference of the case to the Appeals Panel was lawful and wrong in her conclusion that the reasoning of the Appeals panel was adequate.

Post-hearing events

67. There were a substantial number of documents produced to this court which related to events after the decision of the judge. They comprised clinical notes covering the period until the end of 2016. It is only necessary to refer briefly to some of the

matters. They show, in short, that in the result the transfer to Broadmoor had plainly been the right decision both in the interests of the public and the claimant.

Treatment at Broadmoor

68. After transfer to Broadmoor, he was treated under the supervision of Dr Callum Ross, a forensic psychiatrist at Broadmoor. By mid-July 2015, his condition was such that testosterone treatment could commence. On 29 July 2015, Dr Callum Ross told the claimant he would not treat him with clozapine.

The further decision of the Crown Court on 18 September 2015

69. As I have set out at paragraph 36, the Crown Court at Maidstone ordered on 18 September 2015 that within 28 days of the order that the claimant should be admitted and detained at Broadmoor. In making the order, the court had the evidence of Dr Callum Ross, and of Dr Andrew Iles, a consultant psychiatrist at St Andrew's Healthcare expressly instructed on behalf of the claimant by the solicitors acting for him in the criminal proceedings, Kaim Todner.
70. Dr Callum Ross assessed the claimant as providing a high risk of harm to others, the latest attack being in May 2015; in high security conditions the risk of absconding was low, though he had absconded in August 2013 and October 2014 when held in conditions of medium security. It was evident that the claimant was making progress at Broadmoor. Dr Ross' clear opinion was that his treatment should continue in conditions of high security at Broadmoor:

I consider the risk of harm that [the claimant] presents to others is still an immediate one and there is the potential for grave harm to result if cared for at the immediate and present time in lesser secure conditions.

Dr Ross asked that a further restriction order be made under s.41 of the MHA 1983, expressly doing so in the knowledge that he was already detained under an earlier order.

71. Dr Iles had seen the claimant at Broadmoor on 1 September 2015 and had participated in the review of the claimant's first three months in Broadmoor. He also assessed the claimant as demonstrating a significant risk of future violence. Dr Iles considered that the bed at Broadmoor should continue to be made available until the claimant was able to step down to conditions of medium security. Such conditions were likely to be under Dr Iles' care at the Medium Secure Unit in the Midlands.

Subsequent events

72. On 12 October 2015, the First Tier Tribunal (Judge Philip Westcott, Dr Deo and Mr Powell) considered the reference of the claimant's case by the Secretary of State under s.71(2) of the MHA 1983; the unanimous conclusion was that he had to remain in detention under ss.37/41. Dr Callum Ross gave evidence to the effect that the claimant was fit for transfer to a Medium Secure Unit. In an observation (which was unreasoned), the Tribunal commented that he appeared to be "entirely inappropriately" placed at Broadmoor.

73. On 1 December 2015, Dr Monks in a careful and clear letter recommended transfer to the Medium Secure Unit in the Midlands for a trial period. Arrangements to progress the transfer were then made, resulting in the transfer to the Medium Secure Unit in the Midlands on the first day of the hearing before this court.

The proceedings in the Court of Appeal

The way the case was advanced at the hearing in the Court of Appeal

74. In the light of the time that had elapsed since the decision of the judge and the successful treatment at Broadmoor, the question arose as to whether the proceedings before this court should have been pursued. When this was put to leading counsel who had been instructed in the hearing before us, the justification for continued pursuit of these proceedings was said to be:

- i) to give the court an opportunity of setting out the legal safeguards (including judicial scrutiny) where a vulnerable person was transferred into high security conditions;
- ii) to obtain the declaration that the transfer to Broadmoor was unlawful as it would highlight the importance of transgender issues being given proper weight because the real problem here had been the failure to treat the claimant's gender dysphoria.

It was submitted that transgender issues had only recently been catapulted into public consciousness. Gender dysphoria was not a mental disorder and was common amongst transgender persons; it was simply a health need which could be treated at gender identity clinics. Like other health needs failure to treat it could have serious consequences.

75. It was contended in support of the general submission before us, particularly in the post-hearing submissions made in January 2017, that the regime at Broadmoor as applied to the claimant was not the least restrictive within the Code:

- i) The high security conditions at Broadmoor, though permitted under the MHA 1983 and The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013 made under powers conferred under the National Health Service Act 2006, were restrictive within Article 8. Incoming and outgoing mail and other items are subject to security inspection; phone calls are subject to supervision. No such restrictions applied at Medium Secure Units. There was also greater searching of patients and their rooms and greater control over their personal possessions. They were subject to greater curtailment of movement in the hospital by measures such as the locking of doors and restrictions on access to the grounds. The restrictions of the Broadmoor regime far, from being necessary, were in the case of the claimant much more severe as a result of his gender dysphoria; at the time of transfer it was anticipated he would need observations within close proximity (for example at arms-length) including the possibility of 2:1 observations.
- ii) It was likely that his detention under the MHA 1983 would be prolonged by transfer to Broadmoor.

- iii) Although it was accepted that the claimant had benefitted from his treatment at Broadmoor, these benefits were irrelevant to the justification for the purposes of the Code and the claimant's Convention rights.
76. Article 3 was engaged as, particularly given the claimant's gender dysphoria, the anticipated conditions of detention at Broadmoor could amount to inhuman or degrading treatment; the restrictive conditions would be exacerbated by the denial of treatment by clozapine (which the claimant wanted) and the non-consensual treatment by anti-psychotic injections and the delay in treating his gender dysphoria. For the same reasons, Article 8 was also engaged.
77. As these articles were engaged, the defendants had to show convincing reasons for the transfer to Broadmoor. It was submitted on the basis of the decision of the Strasbourg Court in *Herczegfalvy v Austria* (1993) EHHR 437 and Articles 3 and 8 that the court had to satisfy itself that the medical necessity for the transfer has been convincingly shown to exist. A proper search for a Medium Secure Unit had not been made and the option of admission for a short terms crisis admission had not been explored. It was not therefore a case where clinical judgement could be relied on in answer.
78. Submissions similar to those made before the judge were made in relation to the procedural issues raised in relation to the Broadmoor panel.

My conclusion on the facts

79. On the assumption that Articles 3 and 8 were engaged and the respondent trusts had to show that transfer was necessary under a full merits review by the court, I am sure that there was no breach of either article and the claimant's transfer was absolutely necessary. The claim fails completely on the facts, as McGowan J correctly held. It failed even on this very high basis which as I will explain was wrong in law.
- i) The contention that Oxleas should have found another Medium Secure Unit is hopeless. The evidence was clear that no other unit would be prepared to take him.
 - ii) The whole history of his treatment at the Bracton Unit demonstrates that every effort was made to treat his mental illness, despite the increasing violence he exhibited.
 - iii) By the beginning of 2015, it was clear that the state of his mental illness was such that the restrictive conditions which would be provided at Broadmoor were necessary. As is evident from the facts set out, he could not be managed safely at the Bracton Centre or any other medium secure setting. This was the least restrictive regime under which he could be treated.
 - iv) There was clear justification for not giving him clozapine. Adherence to the treatment is essential because stopping and starting can cause a deterioration in mental state and cardiovascular collapse. As the claimant could not, in the light of the extensive history, be relied on to take the medication regularly, the conditions necessary for its successful use could not be met.

- v) The conditions in Broadmoor to which it was likely the claimant would be subjected could not and did not amount to inhuman or degrading treatment. The Article 3 claim was hopeless on the facts and should never have been advanced. Indeed it might be said to be gratuitously offensive to make such a case against the two hospital trusts who had done so much to try and treat the claimant in the best manner possible.
 - vi) The restrictions that might be imposed at Broadmoor were both necessary and proportionate for the purposes of Article 8. There was no breach of that article.
 - vii) The claimant's mental condition was not attributable to a failure to treat his gender dysphoria; he had a clear and long standing diagnosis of personality disorder with psychotic episodes and possible schizophrenia. On the facts, I am entirely satisfied that the first step was to treat his mental illness so he had a period of stability which would enable his gender dysphoria to be treated. The evidence of the treating psychiatrists is clear and to be preferred to that of Dr Barrett and Dr Page who had significantly less knowledge of the claimant than the highly experienced psychiatrists who treated him at the Bracton Centre and who assessed him for Broadmoor. In particular, the criticisms made by Dr Page of the staff at the Bracton Centre were in my view entirely unfair and without justification. It was entirely wrong of her to characterise the staff at the Bracton Centre as being "unsympathetic". It is to be noted that none of those who provided reports that were submitted on behalf of the claimant was in a position to or was prepared to treat him.
80. As regards the specific point on the procedural unfairness in Broadmoor re-considering the matter by way of appeal rather than by a further panel hearing, there was no unfairness. It was right to proceed in the way in which Broadmoor did. The panel's reasons were plainly clear and sufficient as is evident from reading them. The attack on the reasoning was simply a collateral attack on the decision and therefore could not succeed for the reasons I have given.
81. That is enough to dispose of these proceedings which should clearly have been withdrawn after the hearing before the Crown Court in September 2015 and the Order of that Court. The claim simply fails on the facts, even on the wrong basis on which it has been advanced.
82. I must also make clear I do not accept the contention that the pursuit of these proceedings before us was necessary in order to obtain the declaration sought to highlight the importance of transgender issues being given proper weight. There is no ground for suggesting that the doctors treating the claimant either at Bracton or at Broadmoor failed to appreciate the importance of the claimant receiving treatment for gender dysphoria. Bracton referred him to the appropriate specialist unit at Charing Cross, who were willing to treat him but only when some stability had been achieved in his mental state and behaviour. There was, as I have said, a delay in his follow-up appointment at Charing Cross in the middle of 2014 because of diary and administrative errors; but a mistake of that kind does not call for a declaration of the kind suggested. His treatment at Charing Cross continued following his transfer to Broadmoor.

The proper approach to such cases

83. However, in the hope that such waste of public funds can be avoided for the future, I would wish to make it clear the following.
84. The position in relation to such transfers was clear from two first instance decisions by Richards J and Munby J (as each then was):
- i) In *R(P) v Mersey NHS Trust* [2003] EWHC 994 (Admin), a challenge was made to the refusal by the Secretary of State to direct the removal of a patient subject to a s.37/41 hospital order from a High Security hospital to a medium security hospital. In refusing relief Richards J said:

“[25] In my judgment the central question in this case is whether the risk posed by the claimant is sufficiently low to make it appropriate for him to be accommodated in medium security rather than high security. If it is, then plainly there is a case for transfer; if it is not, his continued detention in conditions of high security is plainly a justifiable interference in his Article 8 rights.

[26] Who is to decide that question of risk? That is really the stark issue raised by Mr Bowen's submissions. Is it the persons upon whom the statutory powers have been vested by Parliament? Is it the Tribunal or the court? In my judgment the answer is clear. The decision must lie with those in whom Parliament has vested the statutory powers and who are thereby made responsible for forming the necessary judgments upon which the exercise of the statutory powers is necessarily based. That applies in particular to the Secretary of State who has ultimate responsibility under all the relevant statutory provisions, either as the person with power to direct or as the person whose consent is a precondition to the exercise of the powers by others. The statutory scheme is clear. It is not for the court to substitute its judgment for the statutory decision-maker.

[27] The process contemplated in *Wilkinson* in hearing expert evidence, including cross-examination, which is the process that the claimant invites the court to adopt in the present case, seems to me to relate to a very different context. This is a situation where the court can and should acknowledge that the statutory responsibility has been vested in others. It should afford to the decision-maker a margin of discretion, though of course it will look carefully at the basis of the decision and at the judgment reached and will examine in particular whether all relevant evidence has been taken into account and, where there has been a recommendation, albeit an extra-statutory recommendation by the Tribunal, whether that recommendation has been properly taken into account. The court's role is, however, the secondary one of determining whether the decision-making

process has been a proper one and whether the judgment reached is one reasonably open on the evidence.”

- ii) In *R(IR) v Shetty* [2003] EWHC 3022 (Admin), an attempt by a convicted prisoner who had been transferred to hospital under s.47 of the MHA 1983 and opposed his return to prison, Munby J (as he then was) expressly followed and affirmed the decision of Richards J.

85. This approach is entirely in line with the decision of this court in *R(L) v West London Mental Health NHS Trust* [2014] 1 WLR 3103; [2014] EWCA Civ 47. In that case this court had to consider a challenge by way of judicial review to a decision to transfer a patient detained under a s.37/41 hospital order from a Medium Secure Unit to a high security unit (Broadmoor). After considering what was required by way of a fair procedure, the court said:

78. There are, however, several other factors in the present case which justify circumspection. They do this in a similar way to the way that the factors to which I refer at para 76 have limited the requirements of what material must be made available or the scope of the individual's participation. The first factor is that, as recognised by this court in *R v Secretary of State for the Home Department, Ex p Pickering* [1990] COD 455, the decision in this case is a clinically-based medical evaluation of future risk to the patient and to others. See also the references to the need for respect for clinical judgment in different mental health contexts in *R (Wilkinson) v Broadmoor Special Hospital Authority*, para 79, per Hale LJ in relation to imposed treatment (proper respect for “therapeutic necessity”) and in *R (K) v Camden and Islington Health Authority* [2002] QB 198, para 58, per Sedley LJ. The second is that the evidence in these proceedings shows there is often a need for transfers to be executed with urgency because of the inability of the medium security hospital to continue to look after the patient safely, and the immediate risk to that patient and other patients, and to staff. The third factor is that the decision has a “rationing” aspect because of the scarcity of high security places in hospitals. The admission criteria are inter alia directed to ensuring consistency in the admissions standards used by the three high security hospitals. ...

80. The clinical decision is one that is made on the basis of the entire clinical and other history of the patient in question. The incident which is the trigger to the reference is typically only part of a much larger picture that has to be considered, and subtle nuances in the description of the facts of that incident are unlikely to affect the overall decision

86. The issues relating to transfer as set out in these cases are quite different from the circumstances that arose in *R(Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419. The court was there concerned with a case of the compulsory imposition of treatment under s.58 of the MHA 1983 without the consent of a patient

detained under a hospital order. As Hale LJ said, there was no reason to distinguish as regards consent between a person who lacked capacity but was not detained under a hospital order and a person detained under a hospital order. In that case a full merits review was justified.

87. I cannot see any basis for extending the scope of the *Wilkinson* decision as it would involve a major change in the law which has been clear since the two first instance decisions to which I have referred and which were plainly right. Moreover, if a full merits review were required, some cases might involve the full panoply of oral evidence and cross-examination: see *R(JB) v Haddock* [2006] EWCA Civ 961. If such a process was required, then it would impose severe delay and high cost to no public benefit to a case such as the present where the considerations are much broader.
88. In my view, when a challenge is made in the Administrative Court to the lawfulness of decisions involving the transfer into or out of a High Security Hospital, the court will pay the highest regard to the *bona fide* professional judgement of the responsible clinician. If the decision is *bona fide* (and there can, as I have explained, be no possible doubt that the judgement of the responsible clinicians in this case was *bona fide*), it would require compelling evidence to show that that judgement is one to which the court should not pay the highest regard. In my view, such judgement would generally be sufficient evidence on which a court could determine the lawfulness of the decision to transfer, absent compelling evidence to the contrary. There was no evidence (let alone compelling evidence) in this case to show that the judgment of the responsible clinician was not one on which the court could safely rely in determining the lawfulness of the decision.
89. Parliament has, as Richards J made clear, given a role to the Secretary of State and provided for review of detention by the First Tier Tribunal. Applications for judicial review of decisions to transfer should therefore be very rare indeed. In *R v Vowles and others and R(Vowles) v Secretary of State* [2015] 1 WLR 5131, this court sitting in its Criminal Division and its Civil Division, considered the approach a Crown Court should take to the making of hospital orders, the role of the Secretary of State and the role of the First Tier Tribunal. The interposition of challenges to transfers save in the rare circumstances to which I have referred would interfere with the proper operation of a carefully balanced system which seeks to protect the public from a convicted criminal who continue to pose a serious risk to the public in a way that also protects the interests of the convicted criminal.
90. Although the nature of the regime for treatment at a High Secure Unit such as that at Broadmoor is more restrictive than the regime at a Medium Secure Unit, the decision to transfer was for the reasons I have given unimpeachable. Once that decision is made, the extent of the detailed operation of that regime such as the observations necessary for the safety of others and of the patient are matters for the detailed operation of the regime and not for the court.
91. I would add that the decision of the responsible clinician not to treat with clozapine (a matter which was one of the key issues in the decision) was a matter of clinical judgement for the claimant's responsible clinician. The court cannot order a clinician to carry out treatment that presented significant risk to his mental and physical health contrary to the clinician's *bona fide* professional judgement: see: *R (Burke) v General Medical Council* [2006] QB 273 at paragraph 50 and *AVS v A NHS Foundation Trust*

[2011] EWCA Civ 7 at paragraphs 36-39; *R (K) v Camden and Islington Health Authority* [20012] QB 198 at paragraph 55, *R (H) v Home Secretary* [2004] 2 AC 253 at paragraph 29.

92. There is one final observation. The claim that the reasons given by the Appeal Panel at Broadmoor were inadequate was hopeless. It was simply another device for disputing the decision; the reasons were in themselves clear and cogent. Nothing elaborate is required. A challenge to the adequacy of reasons is rarely, if ever, appropriate. It certainly should not be used, as it was in this case, as collateral means of challenging the merits of the decision.

Conclusion

93. I would dismiss the claim.

Lord Justice Underhill

94. I agree.

Lady Justice Hallett

95. I also agree.