Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: DA/00247/2014

THE IMMIGRATION ACTS

Heard at Phoenix House, Bradford
On 3rd March 2015

Determination Promulgated
On 30th March 2015

Before

UPPER TRIBUNAL JUDGE COKER

Between

KEITH HOKO

Appellant

And

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Mr A Siddique of Parker Rhodes Hickmotts solicitors
For the Respondent: Mr M Diwnycz, Senior Home Office Presenting Officer

DETERMINATION AND REASONS

1. Following a hearing on 6th November 2014 I found an error law in the following terms in the determination of the First-tier Tribunal such that the decision is set aside to be remade.

    1. The appellant appeals a decision of the First-tier Tribunal, which dismissed his appeal against a decision by the respondent to refuse to revoke a deportation order. The appellant had pleaded that his removal would be a breach of the refugee convention and Article 3 and 8 of the ECHR. The First-tier Tribunal judge found that the appellant was excluded from international protection on refugee grounds and considered his appeal on human rights grounds only. He dismissed the appeal on grounds that he would be at risk of being persecuted for his imputed political opinion. The remaining heads of his grounds of appeal

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were his mental health and the risk of suicide and Article 8 because of family and private life. The First-tier Tribunal judge found [22]:

> "I am not satisfied that there is a real risk that the appellant would take his own life if he were faced with a forced return to Zimbabwe. Dr Buller describes the "possibility" of self-harm. He does not however suggest that this extends to a real risk of suicide. Moreover, the appellant's medical condition is not otherwise life threatening. Suitable anti-psychotic drugs are readily available in Zimbabwe. The fact that this may be at cost is irrelevant. As previously noted, there is no evidence that mood stabilising medication would be unavailable to him in Zimbabwe. I have noted from the sources that are cited at pages 54 and 155 of the appellant's bundle of documents, that the provision of psychiatric services in Zimbabwe is limited. It nevertheless exists. I am not therefore satisfied that there is a real risk that the appellant would suffer inhuman or degrading treatment in Zimbabwe due to a lack of appropriate medical treatment, whether for a terminal condition or otherwise. It follows that his removal would not result in a breach of his rights under Article 3 of the European Convention for the Protection of Human Rights and Fundamental freedoms. For the same reason, I am satisfied that removal would not interfere with his right to respect for moral and physical integrity under Article 8. If however I am wrong in this – and Article 8 is engaged by reason of the effect that removal might have upon his medical condition – then I consider that the appellant's removal would be proportionate in order to protect the rights and freedoms of others. The very fact that the appellant suffers from Schizo- affective disorder means that there is a real risk that he will cause serious harm to others. That risk will continue regardless of whether he is threatened with imminent removal. This is because he in any event has an ambivalent attitude towards taking his psychiatric medication. I am therefore satisfied that his removal is justified by reference to one of the legitimate aims…"

2. Permission to appeal had been granted on the basis that it was arguable that the judge had failed to have adequate regard to the two medical reports produced with regard to his assessment of the risk of self-harm and a consequent breach of Article 3. The grounds seeking permission refer to the reasons for the challenge to the Article 3 "health" findings, adversely infecting the Tribunal's findings and that they amount to a breach of the appellant's physical and moral integrity. Permission was neither granted nor refused on that ground and I therefore treat it as a live issue.

3. There had been no challenge to the findings of the judge with regard to the appellant's claim for international protection on the basis of his claimed risk of being at risk of being persecuted for his imputed political opinion.

4. Before me Mr Siddique confirmed that the appellant was not pursuing the asylum aspect of his appeal but that in addition to the Article 3 "health" risk, the Article 8 aspect was connected to the risk of suicide and thus was pursued although he made no specific submissions in this regard.

5. Mr Siddique submitted that relevant elements of the medical reports had been omitted in the summary set out in [19] of the determination. In particular he refers to the recent history of self harm and the recent incident where the appellant went to a bridge and heard voices telling him to jump off. He submitted that the judge failed to take this into account in his assessment of

future risk and that the low to moderate risk of suicide becomes high if the appellant becomes unwell. The issue of risk was elaborated upon by Dr Pick who agreed with Dr Buller. Although medication exists in Zimbabwe it was incumbent upon the judge to consider and asses its accessibility given that the medical evidence was that if the appellant did not access his medication he would become unwell and would become at high risk to himself and others. There was no indication that the judge had considered J [2005] EWCA Civ 629 in reaching his conclusions.

6. Mr Diwnycz disputed that there had been inadequate consideration of the evidence or that J had not been considered. Although there had been no mention of J by name it was plain that the principles had been adequately and correctly applied. He referred to the language used by the two psychiatrist and submitted that both had applied the test of 'real risk' as required; Dr Pick's report stopped at saying the risk was significant rather than stressing it would be "highly likely" or "real". The use of these words to connote the test to be applied was challenged by Mr Siddique who asserted that these words were relevant to the balance of probabilities and not the test relevant to Article 3.

Undisputed findings

7. In [19] the First-tier Tribunal judge made the following undisputed findings:
   (1) The appellant suffers from Schizo-affective disorder. His symptoms are characterised by a combination of both psychotic and manic symptoms…
   (2) He requires indefinite (most likely lifelong) treatment with a combination of both antipsychotic and mood stabilising medication…He is at present being treated with a combination of Chlorpromazine (an antipsychotic drug) and mood stabilisers (Depakote and Lithium)…
   (3) There are five different antipsychotic drugs that are readily available in Zimbabwe [the letter from the FCO]. One of these (Thioridazine) is considered by the UK medical authorities to be generally inappropriate due to its impact on cardiac conduction, and another (Olanzapine) would be unsuitable for the appellant because of his cholesterol problems. Whilst the remaining drugs might constitute appropriate treatment for the appellant's psychosis, they would need to be combined with mood stabilising medication…
   (4) There is no evidence that mood stabilising drugs are unavailable in Zimbabwe. I express the finding in that particular way because the burden of proof is upon the appellant.
   (5) The appellant's bouts of mental illness are associated with significant risk of harm both to himself and to others…
   (6) The appellant's most recent relapse was due to his failure to take psychotic medication over a period of a month. This was due to the stress of these proceedings *and* his ambivalence towards taking his psychiatric medication. There is a high risk that he will relapse again if he fails to take his medication…
   (7) It is "possible" that a fear of forced return may provoke the appellant to "an impulsive act of self harm"…

8. In response to a question from me as to whether there were any elements of the psychiatrist evidence that had been left out of account Mr Siddique referred to the following:
   (1) the reference by Dr Buller to the most recent relapse where the appellant had gone to a bridge and had heard voices telling him to jump off resulting in him being sectioned…

(2) that if the appellant becomes unwell he presents as a high risk of suicide and it is whilst on medication that he presents as low to moderate risk…
(3) that both psychiatrists demonstrate how quickly the appellant can become unwell…
(4) that becoming unwell is related not just in terms of lack of medical treatment but also the effect of stress of forced removal to Zimbabwe…
(5) accessibility of medication is relevant to the assessment of risk…

9. Although the determination considers the medical evidence, the concentration by the judge on the use of the word "significant" by the psychiatrists rather than the terms used in the Rules of "real risk", has led the judge into error in his assessment of the medical evidence. There was no adequate consideration by the judge of the most recent attempt by the appellant to attempt suicide, which was clearly a serious attempt that was only thwarted by a passer bye. There has been no adequate assessment of the appellant's access to medical care in Zimbabwe which although not determinative, is certainly a matter which has to be factored in given the strong medical evidence of potential self harm in the absence of adequate care. A further factor that may be relevant is that the appellant became ill whilst in the UK and sought and was provided with treatment here.

10. Taking all of these factor together and recognising that this is a difficult case to which the First-tier Tribunal judge evidently gave considerable and serious thought, I am nevertheless satisfied that the judge has erred in law in his approach to the medical evidence. I am satisfied that the determination should be set aside to be remade in so far as Article 3 is concerned.

11. I heard no specific argument as regards Article 8, the submissions being subsumed into Article 3. Although there was no specific argument it is appropriate in the circumstances of this appeal for the appellant to have the opportunity to argue Article 8, given the close connection with the Article 3 grounds.

12. Before me, I heard submissions on the basis that if I did set aside the decision, I would not have to reconvene the hearing. The parties would inform the tribunal whether they intend to call one or other of the psychiatrists to give oral evidence.

13. Having reconsidered this I am now of the view that given the nature and extent of the medical evidence that is to be considered, it is appropriate for an oral hearing to be listed before the Upper Tribunal for submissions. If the parties wish to call one or other psychiatrist to give oral evidence they are to notify the Tribunal within 14 days of promulgation of this determination.

Conclusions:

The making of the decision of the First-tier Tribunal did involve the making of an error on a point of law.

I set aside the decision to be remade

Consequential Directions

If either party wishes to call oral psychiatric evidence they are to notify the Upper Tribunal within 14 days of promulgation of this decision.

Both parties to file and serve a skeleton argument no later than 3 days before the date of hearing.

The resumed hearing to be listed for 2 hours, submissions only save as indicated above.

Resumed hearing

2. Mr Siddique, in his skeleton argument, stated that Article 8 was not being pursued. I heard submissions from both parties and drew the attention of the parties to GS [2015] EWCA Civ 40.

3. The claimants in GS all suffered from very serious medical conditions and it was accepted that their life expectancy on return to their home country was extremely diminished. GS considered the relevant jurisprudence and despite the consequences, found that none of the claimants were successful in their Article 3 claims, no matter the clear adverse effects that refusal would bring.

4. The medical aspects of those claimants are different to that of this appellant, whose medical condition stems from psychiatric illness. I heard oral evidence from Dr Pick. He was impressive in his explanation of the appellant's condition and did not seek to exaggerate the consequences to the appellant of a change in medication. He described the appellant as being at the extreme end of the spectrum for his illness because he relapses so quickly and the relapse is so severe. He becomes rapidly disorientated, hears voices not only telling him for example to jump from a bridge but also that he would survive such a jump. Dr Pick described how the appellant had on occasion to be placed in a locked room totally without stimulation in order to enable him to be brought down from his dangerous state. He said this was a treatment used very rarely now and indicated the serious nature of the appellant's illness. Professionally his concern was that the appellant can be reckless with a grandiose sense of his own strength alongside voices commanding him to do things seriously adverse to his survival. The appellant has been gradually deteriorating over the years and now he would not be able to adapt to change, as he would have been able to, say 10 years ago. He has no social life outside the professionals with whom he has contact and the day centre he attends. He can deteriorate very quickly; here in the UK he can be collected and taken to a place of safety. What is seen during this deterioration is a very angry man, not a man who is mentally unwell; the appellant has a chronic mental illness with acute relapses. Dr Pick expressed the opinion that deportation increased the risk of relapse; the appellant would not be able to adapt and this in turn leads to an increased risk of self-harm.

5. In so far as the drugs available in Zimbabwe were concerned Dr Pick said the following: a change in drug regime has to be managed by the reduction of the drugs he is currently on and then after that reduction has taken place, an increase in the other drug. The transition to change medication is in the region of 2-4 weeks; there is a time lag of anti-psychotics taking effect of 4-5 days and so the full effect of the new drugs could be 3-4 weeks. There are risks associated with that for anyone. In so far as the appellant is concerned his history of rapid deterioration adds to the concerns of managing a change in

drug(s). The change has to be very carefully monitored. Other anti-psychotics that have been used in the past have not been effective. Lithium was unsuccessful because the appellant did not manage to take it with the care required. The same was for other anti-psychotics. The current medication and dosage is one that has been tried and established over the years as suitable for the appellant. The options available for the appellant are limited and the risks associated with relapse during any change are significant. He has been on the current medication since 2007 and although this medication is not perfect it is providing a degree of stability. Any change had to be carefully managed and monitored.

6. The drugs available in Zimbabwe according to the letter dated 5 February 2013 from the Foreign and Commonwealth Office and their suitability for the appellant are, according to Dr Pick, as follows:

Olanzapine	not tolerated
Haloperidol	the appellant was on this but taken off in 2007 because it was not tolerated
Thioridazine	unsafe because of possible cardiac side effects
Respiridone	the appellant has not tried this
Trifluoperazine	this is a drug rarely used in the UK; it is one of the older anti-psychotics (as is Thioridazine); there are possible cardiac side effects although Dr Pick could not say this for certain.

7. Dr Pick, in response to a question from me, said that as soon as it became apparent that the appellant would be removed from the UK the medical team responsible for his care would set in motion, as much as was possible, a regime to enable risk to be minimised.

8. The written reports by Dr Buller and Dr Pick paint a picture of a highly disturbed man who consistently over time made a wide range of threats to staff and also perpetrated violence. These threats include specific threats of killing staff, sexual violence towards female staff in addition to self-laceration. The threats of violence to others have diminished.

9. There was no challenge by Mr Diwnycz to the evidence of Dr Pick or the medical reports. I accept in full the evidence given; Dr Pick in his oral evidence was impressive, clear and constructive. When considered alongside the reports it is plain that after a very short time in Zimbabwe, the appellant will not be able to access drugs suitable for his illness; not because he cannot afford them but because they do not exist there. The only drugs available are unsuitable save for Respiridone which has not been tried. There is no suitable combination available and in any event it is highly unlikely (see below) that the necessary managed change to the drug regime would be available.

10. The appellant has no friends or relatives in Zimbabwe and no friends or relatives in the UK.

11. Zimbabwe has a population in excess of 14 million. The background material on country conditions in Zimbabwe refer to an improved access to general health care and improving access to drugs and treatment. But the situation for mental health remains poor. The US State Department Report 2013 published on 27th February 2014 says:

> "Persons with mental disabilities also suffered from inadequate medical care and general provision of health services. There were eight mental health institutions in the country with a capacity of more than 1,300 patients, in addition to the three special institutions run by the ZPCS for long-term patients and those considered to be dangerous to society. Inpatients in the eight centralized institutions received cursory screening, and most waited for at least one year for a full medical review. A shortage of drugs and adequately trained mental health professionals resulted in patients not being properly diagnosed and not receiving adequate therapy. There were fewer that 10 certified psychiatrists working in public and private clinics and teaching in the country. There was a 50 per cent vacancy rate for psychiatric-trained nurses. More than 90 percent of the available psychiatric services were provided at the mental institution in Bulawayo. NGOs reported that patients were subjected to extremely poor living conditions due in part to shortages of food, water, clothing, and sanitation. Budgetary constraints and limited capacity at these institutions resulted in persons with mental disabilities being kept at home and cared for by family, sometimes in chains and without treatment.
> Prison inmates in the three facilities run by the ZPCS were not necessarily convicted prisoners. Inmates with psychiatric conditions were examined by two doctors, who were required to both confirm a mental disability and recommend that a patient either be released or returned to a mental institution. Prisoners with mental disabilities routinely waited as long as three years before being evaluated."

12. There was no more up to date background material as to the state of health services for mentally ill individuals in Zimbabwe. Mr Diwnycz submitted that although the services and facilities available were not to the standard available in the UK, the lack of facilities did not meet the very high threshold required to amount to a breach of Article 3. He submitted that there were possible drugs available to the appellant in Zimbabwe.

13. Mr Siddique relied in particular upon J v SSHD [2005] EWCA Civ 629 and Y & Anor (Sri Lanka) v SSHD [2009] EWCA Civ 362. He submitted that there would be a risk of suicide both in the UK when the appellant was faced with actual removal pursuant to the deportation order and in Zimbabwe.

14. Article 3 provides

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

15. GS surveyed the relevant jurisprudence. In [39] Lord Justice Laws says:

> 39. As regards Article 3 the Strasbourg court has repeated time without number that "to fall within the scope of Article 3 the ill treatment must attain a minimum level of severity". But this formula is at too high a level of generality to provide, or even suggest, a paradigm. In my judgment the language of the Article shows that

> the paradigm case of a violation is an intentional act which constitutes torture or inhuman or degrading treatment or punishment…."

He goes on to consider the paradigm as evaluated in Bensaid v UK (2001) 33 EHRR 205, D v UK (1977) 24 EHRR 423 and N v UK (2008) 47 EHRR 39. D and N refer to article 3 principally applies to prevent a deportation or removal where the risk of ill treatment in the receiving country emanates from *intentionally inflicted acts of the public authorities.* He refers to [43] of N;

> 43. The court does not exclude that there may be other very exceptional cases where the humanitarian considerations are equally compelling. However it considers that it should maintain the high threshold set in *D v the United Kingdom* and applied in subsequent case-law, which it regards as correct in principle, given that in such cases, the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-State bodies, but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country.

Between [46] and [67] Lord Justice Laws in GS considers and analyses departures from the Article 3 paradigm. Having referred to N [42] to [45] and [OI-6] of Mwanje v Belgium (2013) 56 EHRR 35 and considered MSS v Belgium & Greece (2011) 53 EHRR2, Sufi & Elmi v UK (2012) 54 EHRR 9, SSHD v UK (2013) 57 EHRR 18 and Tarakhel v Switzerland (Application no 29217/12) Lord Justice Laws said:

> "52….the gravity of what may befall an Article 3 claimant is not the only test of his claim. It has to be shown that the impugned State should be held responsible for his plight. As regards that, the nature of the paradigm case and the scope of its proper expectations are surely critical….
> ….
> 59. Thus in *MSS* and *Sufi & Elmi* the court looked for particular features which might bring the case within Article 3, and found them – in Greece's legal duties and the applicant's status as an asylum seeker, and in the nature of the crisis in Somalia.
> 60. One may contrast the case of *SSHD v UK (2013) 57 EHRR 18*, in which a severely disabled Afghani claimed that he would face a real risk of ill treatment if he were returned to Afghanistan. The court referred to both *MSS* and *Sufi & Elmi* (see paragraph 76 and 77) but followed neither; it held that the correct approach was that set out in N:
>
> > 92. The Court therefore considers that, in the circumstances of the present case where the problems facing the applicant would be largely as a result of inadequate social provisions through a want of resources, the approach adopted by the Court in *N v the United Kingdom*, cited above, is more appropriate. The Court will therefore need to determine whether or not the applicant's case is a very exceptional one where the humanitarian grounds against removal are very compelling"
>
> Applying *N*, the court held (paragraph 95) that no sufficiently exceptional circumstances.
> …..
> 62. ….it is clear that the departures from the Article 3 paradigm given in *MSS* and the other cases to which I have referred do not extend the reach of the departure allowed in *D* and discussed at paragraphs 42-45 in *N v UK*. The plight of an individual whose life expectancy may be severely shortened by his removal or

deportation to his home state is a distinct state of affairs whose treatment under the Convention is not qualified by the court's approach, for example, to the reception conditions for asylum seekers. The circumstances in which a departure from the Article 3 paradigm is justified are variable: the common factor is that there exist very pressing reasons to hold the impugned State responsible for the claimant's plight. But the fact that there are other exceptions unlike *D* or *N* does not touch cases – such as these- where the claimant's appeal is to the very considerations which *D* and *N* address."

Lord Justice Laws cites [15], [36] and [69] of N v SSHD [2005] UKHL 31 and refers to [89-94] as the *ratio decidendi* of N and for completeness I also quote:

> "15. Is there, then, some other rationale [*other than the pressing nature of the humanitarian claim*] underlying the decisions in the many immigration cases where the Strasbourg court has distinguished *D's* case? I believe there is. The essential distinction is not to be found in humanitarian differences. Rather it lies in recognising that article 3 does not require contracting states to undertake the obligation of providing aliens indefinitely with medical treatment lacking in their home countries. In the case of *D* and in later cases the Strasbourg court has constantly reiterated that in principle aliens subject to expulsion cannot claim any entitlement to remain in the territory of a contracting state in order to continue to benefit from medical, social and other forms of assistance provided by the expelling state. Article 3 imposes no such 'medical care' obligation on contracting states. This is so even where, in the absence of medical treatment, the life of the would-be immigrant will be significantly shortened. But in the case of *D*, unlike the later cases, there was no question of imposing any such obligation on the United Kingdom. *D* was dying, and beyond the reach of medical treatment then available." (*per* Lord Nicholls)
>
> "36. What was it then that made the case exceptional? It is to be found, I think, in the references to D's 'present medical condition' (para 50) and to that fact that he was terminally ill (paras 51: 'the advanced stages of a terminal and incurable illness'; para 52: 'a terminally ill man'; para 53: 'the critical stage now reached in the applicant's fatal illness'; Judge Pettiti: 'the final stages of an incurable illness'). It was the fact that he was already terminally ill while still present in the territory of the expelling state that made his case exceptional." (*per* Lord Hope)
>
> "69. In my view, therefore, the test, in this sort of case, is whether the applicant's illness has reached such a critical stage (ie he is dying) that it would be inhuman treatment to deprive him of the care which he is currently receiving and send him home to an early death unless there is care available there to enable him to meet that fate with dignity." (*per* Lady Hale)

16. In J Dyson LJ in paragraph 17 identifies the important distinction both in Strasbourg and our jurisprudence of "foreign" and "domestic" cases. He breaks down three stages (i) when the appellant is informed that a final decision has been made to remove him – domestic; (ii) when he is physically removed – domestic because in practice arrangements are made by the Secretary of State in suicide cases for an escort, and (iii) after he has arrived in his country of destination – foreign. In foreign cases he states (paragraph 27 and 28) that in a 'foreign' case a causal link must exist between the act or threatened act of removal and the inhuman treatment relied upon as violating the appellant' s Article 3 rights and that the Article 3 threshold is particularly high simply because it is a 'foreign' case. In paragraph 31 he says that a question of considerable relevance is whether the

> "removing and/or receiving state has effective mechanisms to reduce the risk of suicide. If there are effective mechanisms, that too will weigh heavily against an applicant's claim that removal will violate his or her Article 3 rights".

17. In so far as 'domestic' cases are concerned, Dyson LJ refers to the different approach because, in particular, the concern to avoid or minimise the extra territorial effect is absent. He refers to the sophisticated mechanisms that exist within the countries signatory to the ECHR to protect vulnerable persons from self harm within their jurisdictions ([31]). In [37] Dyson LJ reiterates that

> "In order to establish the causal link between removal and the threatened breach of Article 3, it was necessary *on the facts of the case* to show that the proposed removal significantly increased any suicide risk that was already present. AS Mr Beal points out, this approach only becomes factually relevant where there is a risk of suicide both in the UK and in the receiving state."

18. In J the appellant's fear of return and the link to his risk of suicide was closely linked to his subjective fear of return which was found not to be objectively well founded; furthermore it was found that he would have the continued support of family in Sri Lanka. In [63] Dyson LJ notes:

> "…Having regard to the very high threshold for article 3 in foreign cases of this kind, the IAT's decision cannot be characterised as perverse. In particular: (i) the adjudicator had found that any subjective fears which the appellant might have on return were not objectively justified; (ii) he would have family support on his return; and (iii) he would have access to medical treatment in Sri Lanka which it was conceded was adequate (the IAT noted in this regard that most of the treatment in the UK consisted in the prescription of anti-depressant medication; he had only been placed in an institutional setting on two occasions)."

19. Although not a part of the judgment of the Court of Appeal, [75] expresses concern at the possibility that J's family may have perished in the *tsunami* and that this

> "…might cause a significant deterioration in the appellant's mental health or render him significantly more vulnerable on his return to Sri Lanka than the adjudicator of the IAT supposed would be the case"

20. In Y and Z [2009] EWCA Civ 362, another Sri Lanka case, Lord Justice Sedley giving the lead judgment identified "tenable concerns about the DIJs appraisal of psychiatric evidence and the availability of treatment and extended family support in Sri Lanka". Y and Z considered whether the fear of return by those appellants fell within the fifth "criteria" in J. that is not in issue in the instant appeal which is primarily concerned with the other issue identified in Y and Z namely the sixth "criteria" – "whether the removing and/or the receiving state has effective mechanisms to reduce the risk of suicide. If there are effective mechanisms, that too will weigh heavily against an appellant's claim that removal will violate his or her article 3 rights."

21. In [40] of Y and Z, Sedley LJ sets out in brief the evidence before him of the availability of psychiatric services in Sri Lanka. This includes that the country

has one of the highest suicide rates in the world, has only 41 qualified psychiatrists and is significantly short of skilled mental health staff; a psychiatrist:patient ratio of about 1:9000 and no known prospect of familial shelter or support. In paragraph [50] he states:

> "The first distinction which it is appropriate to draw in relation to the present case is that, in contrasts with what is envisaged at the end of §N (*Grand Chamber)* the anticipated self harm would be the consequence of the acts of the Sri Lanka security forces, not of a naturally occurring illness. It would be, if it were to occur, the product of fear and humiliation brought about by the brutality to which both appellants were subjected before they fled."

22. In §52 he distinguishes Y and Z from RA (Sri Lanka) [2008] EWCA Civ 1210 where that appellant's account of torture, which was the foundation of the psychiatric prognosis, was rejected and that although there was a suicide risk on return RA had sufficient financial resources to access private health care. He goes on to conclude in the appeals of Y and Z

> 61. The upshot of the material findings and of the expert evidence which (for reasons I have given) stood unshaken, is that, although some psychiatric care is available in Sri Lanka, these two appellants are so traumatised by their experiences, and so subjectively terrified at the prospect of return to the scene of their torment, that they will not be capable of seeking the treatment they need. Assuming (what cannot be certain) that they come unscathed through interrogation at the airport, with no known family left in Sri Lanka and no home to travel to, the chances of their finding a secure base from which to seek the palliative and therapeutic care that will keep them from taking their own lives are on any admissible view of the evidence remote.
> 62. None of this reasoning represents a license for emotional blackmail by asylum-seekers. Officials and immigration judges will be right to continue to scrutinise the authenticity of such claims as these with care. In some cases the Home Office may want to seek its own or a joint report. But there comes a point at which an undisturbed finding that an appellant has been tortured and raped in captivity has to be conscientiously related to credible and uncontradicted expert evidence that the likely effect of the psychological trauma (aggravated in the present cases by the devastation of home and family by the tsunami), if return is enforced, will be suicide.
> 63. On the present evidence, including where material the AIT's evaluation of it, the clear likelihood is that the appellants' only perceived means of escape from the isolation and fear in which return would place them would be to take their own lives. For reasons I have given, the concomitant findings that their fear is no longer objectively well-founded and that there exists a local health service capable of affording treatment do not materially attenuate this risk, which is subjective, immediate and acute.
> 64. In this situation, return would in my judgment reach the high threshold of inhuman treatment unconditionally prohibited by art. 3 of the ECHR.

Discussion

23. On the facts of this case I do not accept that the risk of suicide in the UK demonstrates that the appellant will commit suicide in the UK. He is receiving excellent treatment and those who are treating him are monitoring him closely

and aware of the potential risks. Although there have been suicide attempts and these are increased during poor medication periods, those treating him have in place structures and strategies for monitoring and protecting him. If and when the appellant is notified of actual removal, as Dr Pick said, those treating him would do their best to ensure there were adequate mechanism in place to minimise the risk; such having been the case so far. In the meantime his condition is being adequately monitored and maintained. Of course the risk cannot be obliterated altogether but the treatment available to the appellant here in the UK is such as to minimise it in so far as is possible. Furthermore he will continue on the medication (monitored), which has been deemed to be the most appropriate.

24. In so far as the risk whilst in transit is concerned, the respondent provides medical escorts and those treating him would work closely with the respondent in managing removal and ensuring that the required medication was administered. Again the risk cannot be obliterated but the medical authorities will work closely to ensure that the risk is minimised.

25. The issue as to the ‘foreign’ element is more complex. This appellant is suffering from a naturally occurring illness; in contrast to Y and Z, his condition has not been brought about by any adverse state action or intervention. He is at the extreme end of the spectrum. He would not have access to his current medication in Zimbabwe firstly because it is not available and secondly because there is no-one (friend or family) in the UK who would be able to transmit the required medication to him. Although there is a possibility of alternative medication available its efficacy is currently unknown, it may be contraindicated but there was no significant evidence to that effect but on the other hand it appears, from the availability of psychiatric and medical personnel, that the process of transferring him on to that medication would in all likelihood inadequately monitored and would in itself result in an increased serious risk of self harm and deterioration in his mental capacity. There are 11 institutions for the treatment of mental health inpatients covering a total population in excess of 14 million. The inpatient capacity is likely to be somewhere in the region of 2000 (taking the figure of 1300 for eight institutions referred to in the background material and there additional institutions). Although screening and treatment takes a lengthy period of time, given the seriousness of this appellant’s condition and his extremely rapid decline if inadequately medicated, a delay of even a week or two would result in an extreme deterioration and seriously increased risk. He has no friends or family in Zimbabwe. There is a severe shortage of adequately trained and skilled mental health professionals.

26. The serious harm to which he would be subjected is however as a direct result of inadequate medical facilities in Zimbabwe and not through any state action or inaction. There are some facilities and there was no significant evidence before me to indicate that he would not, because of the manner in which he presents, be transferred to such a facility rapidly. Whilst there is a delay in screening, screening does take place and there is the possibility of alternative medication. This appellant is not in the position whereby he would be kept chained by relatives; my attention was not drawn to any evidence that he would be similarly treated by the authorities in Zimbabwe or in the hospital facilities. Although it is

likely that he will become seriously ill, my attention was not drawn to evidence that he would not access those limited facilities either directly or through the actions of for example the police in detaining him because of his behaviour.

27. The undisputed facts of GS were that he would very likely die within one or two weeks of his return to India. To that extent his case was far more serious than that of this appellant. Although, if not receiving adequate medication and/or treatment, he is at serious risk of self harm it is by no means the case that there is no availability of medication or treatment or that the availability is such that it is reasonable to conclude that because of the seriousness of his condition he would be unable to access such facilities as are available.

28. It cannot be disputed that this appellant's quality of life will seriously suffer if removed to Zimbabwe; but that is not consistent with his assertion that the treatment he would receive there reaches the high threshold required to engage Article 3 protection.

29. The applicant did not, through his legal representatives, pursue his appeal on Article 8 grounds and no submissions were made even though I had granted permission to argue Article 8. The decision of the First-tier Tribunal on Article 8 therefore stands.

30. For these all reasons I dismiss the appeal.

Conclusions:

The making of the decision of the First-tier Tribunal did involve the making of an error on a point of law.

I set aside the decision

I re-make the decision in the appeal by dismissing it

Date **3rd March 2015**

Upper Tribunal Judge Coker