Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: PA/13154/2016 [V]

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On 12 October 2020	**18 January 2021**

Before

UPPER TRIBUNAL JUDGE GLEESON

Between

J R B (TRINIDAD AND TOBAGO)
[ANONYMITY ORDER MADE]

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation

For the appellant: **Ms Nicola Braganza, Counsel instructed by Migrant Action**

For the respondent: **Ms Julie Isherwood, Senior Home Office Presenting Officer**

DECISION AND REASONS

Anonymity order

Pursuant to Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/269) The Tribunal has ORDERED that no one shall publish or reveal the name or address of J R B who is the subject of these proceedings or publish or reveal any information which would be likely to lead to the identification of her or of any member of her family in connection with these proceedings.

Any failure to comply with this direction could give rise to contempt of court proceedings.

Decision and reasons

1. The appellant appeals with permission against the decision of the First-tier Tribunal dismissing her appeal against the respondent's decision on 11 November 2016 to refuse her refugee status under the 1951 Convention, humanitarian protection, or leave to remain in the United Kingdom on human rights grounds. The appellant is a citizen of Trinidad and Tobago.

2. The Secretary of State refused protection and the appellant appealed, first to the First-tier Tribunal, which dismissed her appeal, and then to the Upper Tribunal, which set aside the decision of the First-tier Tribunal, for remaking in the Upper Tribunal. I have received submissions from both parties, each indicating expressly that they are content for the decision to be remade without a further oral hearing.

3. The First-tier Judge's decision was set aside on 23 November 2020, for failure to take account of the medical evidence produced by the appellant or the availability of effective measures to prevent her committing suicide or serious self-harm if returned to Trinidad and Tobago today.

4. The appellant is a vulnerable person. Dr Sridharan, the Consultant Neuropsychiatrist, considered in his main report that the appellant had the capacity to instruct her representatives but not to participate in legal proceedings. If she were required to attend the Tribunal, she would experience significant anxiety and distress, increasing the risk of a severe depressive episode and attempts to self-harm, including suicidal ideation. The appellant was not called to give evidence before the First-tier Judge. No other adjustment for her vulnerability was sought.

5. The appellant has not been able to give evidence in the Upper Tribunal proceedings and her cognitive faculties are declining, which is still being investigated by her doctors. By agreement of both parties, this decision is being remade on the basis of written submissions only, taking into account recent medical evidence from the appellant's consultant neuropsychiatrist, Dr S B Sridharan MBBS MRCPsych and his Community Neuropsychiatry Nurse, Ms Lynn Hollins RMN.

Background

6. The appellant was born in Trinidad and Tobago in October 1972 and is now 48 years old. Her father had serious mental health issues, because of which the appellant says she was bullied at school. In 1974, the appellant's mother left her father and went to live in Venezuela, not returning until 1979, by which time the appellant was strongly bonded to her father, with whom she lived in Indian Walk, Trinidad. The appellant's bond with her mother did not recover and she never felt loved by her.

7. When the appellant was 10, in 1982, her father started living with another partner who treated the appellant very badly. Her natural mother raised this with her father, and by the time that the appellant was 12 years old, her mother had stopped her visiting her father at his house. At about the same time, her father developed paranoid

symptoms, a problem which had also affected two of his brothers. Her stepmother left him, and he lived alone. The appellant was ostracised as the 'crazy man's daughter'.

8. In 1985, when she was 13, the appellant began to have paranoid symptoms, seeing things that were not there, and hearing voices. The voices told her to hurt herself, or to go to places and hurt herself and others. The appellant would scream in her sleep: she still does now, on her account. Her mother told the appellant that she was crazy, like her father and her paternal uncles. There was no help from the church, despite the pastor praying with the appellant. She tried to kill herself by drinking kerosene: her mother called for an ambulance and the appellant was treated in hospital, then discharged after three days.

9. In 1987, when she was about 15, the appellant's father burned down his house and went back to live with his own mother. In the same year, the appellant slashed her wrists, and her mother took her back to the same local hospital. The doctors said she should get the pastor of her Seventh Day Adventist Church to pray for her. He did, but it made no difference.

10. After leaving school, the appellant worked in a shoe store and then in security. Her father came to the shoe shop and started cursing everyone. The appellant was bullied about that and lost her job as she was unwilling to work in the shop, preferring to work where she could not be seen. In her security job, she also tried to be where she could not be seen.

11. In 1990, when she was 18, the appellant had a child with a man who went to live in America, two months after the birth. In 1993, when she was 21, she met a loving partner and lived with him in La-Brea, Trinidad, until 1998, when he died of kidney failure. Her son lived with her until 1997, when he went to America to live with his father and she has seen him only on infrequent visits since then. After her partner's death, the appellant went back to live with her mother in La Romain.

12. The ridicule and abuse continued unabated: sometimes, her father would be walking naked in the street and both of them were ridiculed for being 'crazy'. The appellant came to the United Kingdom for a break in 2005, staying for 5 months and then returning to Trinidad before the expiry of her visit visa.

13. The appellant's case turns principally on the medical and CPN evidence about her health and her vulnerability. The appellant tried, but failed, to commit suicide in Trinidad and Tobago on two occasions before coming to the United Kingdom. The appellant fears return to Trinidad and Tobago because of her medical and family history. Her evidence is that there are people in her home area who would mock and abuse her.

14. The appellant has stayed in contact with her mother and family members in Indian Walk and La Romain, Trinidad, where her problems occurred. Her mother is now over 70 years old and not in good health. The appellant's half-sister and the appellant's son are still living in the United States. The appellant's mother in Trinidad and her sister in

America have sent money when they could, and for a time, she worked at home, doing hair braiding.

15. While living in London, the appellant made one friend, with whom she is still in touch, but now she lives in Stoke-on-Trent and her care has been transferred there. The appellant regards her CNN, Ms Hollins, as a close friend and surrogate mother.

Medical issues

16. The appellant has an organic affective disorder, consisting of recurrent significant major depressive episodes, with psychotic symptoms, self-harm and suicidal ideation. She sees her late father beckoning her and telling her to step under a car, or push someone into danger. She hears abusive remarks by voices in her head. The appellant has attempted suicide on a number of occasions.

17. The appellant has a history of brain operations and problems. Following her return to Trinidad in 2005, in October 2006 a pituitary macro adenoma (a benign tumour on the pituitary gland) was diagnosed and she had three operations to remove it: one trans sphenoidal (through the nose), one sub labial, and one trans frontal, which left her with sight loss in her left eye and loss of smell. The appellant has no confidence in the medical treatment in Trinidad and Tobago following the damage with which those operations left her: she now has pan hypopituitarism (a generalised lack of pituitary hormones). The appellant lost the sight of one eye and continued to face insult and mocking in her home area, reminding her of how her father had been treated. The appellant has a large scar and a squint now, making her an easy target for mockery.

18. In 2008, aged 36, the appellant returned to the United Kingdom on a visit visa, flying directly from Trinidad and travelling on her own passport. She needed a break from her difficulties in Trinidad. This time, she did not return to Trinidad and Tobago but overstayed her visa. The appellant has had no valid leave to remain in the United Kingdom since her visit visa expired on 27 December 2008. The appellant knew that she was in the United Kingdom illegally but could not face returning to Trinidad and Tobago. The respondent has been unable to trace any record of either of the visit visas the appellant says she had.

19. In 2011, while in the United Kingdom, the appellant developed a cerebral aneurism unrelated to her pituitary macro adenoma surgery, for which she had surgery at Kings College Hospital, with coiling of her carotid artery. She was under the care of endocrinologists and was prescribed replacement hormones to deal with her pan hypopituitarism.

20. In 2013, following an MRI scan, the appellant was diagnosed with a suspected glioma (a cancerous brain or spinal tumour). She had developed complications from the 2011 coiling and had further neurosurgical intervention, with a stent being inserted and corrected. These multiple surgeries have left her with brain damage due to vascular lesions and the repeated brain surgeries. The appellant has confidence in her United Kingdom treatment team and in particular, the CNN, Ms Hollins.

21. The appellant's brother died on 28 May 2018. The death certificate described the cause of death as 'metastatic malignancy'. On 11 June 2018, in a report not considered by the First-tier Judge, Ms Hollins recorded that the appellant was not dealing well with the bereavement and had taken an overdose the preceding weekend, the 9/10 June 2018.

22. Dr Sridharan's main neuropsychiatric report dated 16 May 2019 gives the following professional opinion:

> "7.34 If a decision is made to remove [the appellant] from the United Kingdom to Trinidad and Tobago, in my opinion this would result in a significant deterioration of her mood, including suicidal ideation.
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> 7.35 Given the nature of the complex medical condition explained previously, and also significant cognitive problems, I do not think [the appellant] would be in a state of mind to be able to receive information and be reassured, to be able to safely return back to Trinidad and Tobago.
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> 7.36. Furthermore, in my opinion and having known [the appellant's] engagement with the services, I do not think that she would be in a state of mind to be able proactively [to] engage with the services in Trinidad and Tobago and seek support, not only for her neuropsychiatric issues but also for her complex medical issues.
>
> 7.37. It is therefore *highly likely that her condition would deteriorate significantly or she may develop significant and serious thoughts of self harm and attempt to kill herself.*
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> 7.38 The likelihood and risk of suicide would be extremely high." [*Emphasis added*]

23. Three letters from Lynn Hollins RMN, Community Neuropsychiatry Nurse to Dr Sridharan, are relied upon. On 6 February 2020 in a report prepared for the appeal hearing, Ms Hollins said that she had the appellant's authority to share evidence with the Tribunal; that she saw her regularly at her home, in the context of Ms Hollins' role as a CPN; that she usually saw the appellant weekly, except that recently, due to some physical health issues, contact had been less frequent. The appellant was experiencing episodes of dizziness which might be due to low hydrocortisone, and had also had gout and a number of infections.

24. Ms Hollins explained that Dr Sridharan continued to see the appellant every three months, having last seen her in January 2020 with the next review planned for 3 March 2020. Ms Hollins' report in February 2020 was thus an update which would have been included in any consideration by Dr Sridharan in March 2020: it was the latest evidence of the appellant's mental health and the risk to her on return. In her letter, Ms Hollins said this:

> "[The appellant] continues to experience episodes of low mood and she is unable to identify any particular reason for this, although both social isolation and lack of stimulation may be significant factors. During episodes of low mood, [the appellant] continues to present at risk from self-harm. She continues to experience auditory hallucinations which are commanding, and derogatory in nature, which results in significant distress and impacts further upon her mood. [The appellant] is usually able to control and distract herself from these voices *however does respond to the commands on*

> *occasions and has been found to have a cord round her neck and will burn or cut herself.* When low in mood, [the appellant] will withdraw and refuse to take calls from her family and friends, although she continues to engage with her care team.
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> In addition to the auditory hallucinations, [the appellant] may also be experiencing visual hallucinations, and she often reports seeing a figure whom she thinks may be her deceased father. [The appellant] reports the figure calls out to her and she feels compelled to go out looking for 'her father'. This is often after 11 p.m. at night, which presents a considerable risk to [the appellant's] safety, due to the area she currently lives in and her partial sight, which increases her vulnerability. …
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> [The appellant] continues t have a good relationship with her current care team and is always very open and honest about how she is feeling and at times of distress, she feels able to request support, *which I believe has contributed in minimising harm to [the appellant].*
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> There are no plans to discharge [the appellant] from the service at present. There would need to be a sustained period of stability (at least 12 months) in her mental health, with no changes to her treatment regime, before discharge from the service would be considered. As part of the discharge planning process, there would need to be a robust plan in place to ensure [the appellant] has adequate support to maintain her well being.
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> In my professional opinion, [the appellant] needs to continue her current treatment regime, with regular support and close monitoring. *In the event of an enforced return home to Trinidad, her mental health would significantly deteriorate, placing her at significant risk of harm.*" [*Emphasis added*]

25. An updated report dated 24 November 2020 from Ms Hollins has been provided. Ms Hollins reported a further deterioration in the appellant's mental health due to the COVID situation in the United Kingdom and the appellant's awareness of her vulnerability due to her treatment regime. The appellant 'constantly worries for her own safety'. She considered that others in her accommodation were not complying with government guidelines, so she was not using the communal areas of her accommodation during the day, preparing her food at night when the other women were asleep.

26. The appellant had recurrent episodes of low mood, when she would not eat, her sleep was disturbed, she was withdrawn and refused to answer telephone calls, and she would often sit on her bed and 'just cry'. Ms Hollins considered that at such times, the appellant presented a risk of self-harm, although, since she had access to her son and her solicitor, and the support of mental health professionals in the United Kingdom, there had been no recent incidents.

27. The appellant was still having auditory hallucinations, commanding and derogatory in nature, which distressed her: a figure looking like her late father would call to her to push people into the road, or to walk under a car. The appellant felt scared around others and paranoid that people were looking at her.

28. The appellant reported increasing headaches around the site of her previous surgery: she had not had a magnetic resonance imaging brain scan for some years and was worried that there might again be a problem. Her poor vision, and further deterioration in her short term memory, made her life difficult: she lost her mobile phone for two days until she found it in the refrigerator, and she struggled to understand written correspondence, without support and reassurance to facilitate her understanding.

29. Ms Hollins' report concluded:

> "There remain no plans to discharge [the appellant] from the service at present. There continues to be a need for a sustained period of stability (at least 12 months) in her mental health, with a minimal risk to safety, before discharge from the service would be considered. Upon discharge, [the appellant] will require a robust plan in place to maintain her well-being and safety.
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> In my professional opinion: [the appellant] needs to continue her current treatment regime with regular support and close monitoring. In the event of an enforced return home to Trinidad, her mental health would significantly deteriorate, placing her at significant risk of harm. Whilst services may be available back home in Trinidad, [the appellant] has complete trust in her care team in the United Kingdom from both a physical and mental health perspective. This trust results in [her] being able to express any concerns or worries she may have and seeking the support she may need in times of extreme distress, when the risk to safety is heightened. [The appellant] is reassured she will always receive the highest possible quality of care due to the care currently in place to support her, and she acknowledges [that] every endeavour will be made to attempt to maintain her well-being.
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> Past care received in Trinidad has had a significant negative impact on the way [the appellant] feels about both her physical and emotional wellness, s[she] continues to feel very angry regarding her past care/treatment and therefore she is highly unlikely to accept any reassurance given that her safety would be maintained if she were to return."

30. Dr Sridharan also provided an updated report dated 27 November 2020. He stood by his previous opinions. The appellant had been recently referred for a magnetic resonance imaging scan to assess her decline in memory and cognitive functions and a further follow up request from the endocrinologist at Lewisham Hospital had been received.

31. The appellant now needed daily reminders and prompts: Ms Hollins, her CPN, was helping with that. The purpose of the magnetic resonance imaging scan was to see whether there were any new brain lesions or changes that could explain the deterioration in the appellant's memory.

32. Dr Sridharan listed the current diagnoses: pituitary macro adenoma; post-operative blindness in the left eye; pan hypopituitarism; cavernous carotid artery aneurysm; glioma identified in 2013 by an magnetic resonance imaging; organic affective disorder, characterised predominantly by a major depressive episode with psychotic symptoms

and self harm and suicidal ideation; brain damage due to vascular lesions and repeated brain surgeries for both pituitary adenomas and the aneurysm; progressive cognitive decline.

Final submissions

33. For the appellant, Ms Braganza relied on *AM (Zimbabwe) v Secretary of State for the Home Department* [2020] UKSC 17 at [32]-[33], and submitted that the medical evidence now provided indicated that the appellant's mental health had deteriorated significantly, and her vulnerability increased, creating a real risk that removal itself, and her circumstances after arrival, would cause the appellant seriously to self-harm or to commit suicide. In Trinidad she had no support network to assist her effectively to access treatment and the breaking of her bond with Ms Hollins would have a severe debilitating effect on the appellant.

34. There were now highly significant obstacles to the appellant integrating into Trinidad and Tobago: her health, her age, her vulnerability, her lack of support network, and her lack of family, given her mother's age and frailty; her lack of friends in Trinidad and Tobago; and her past there, which would be a significant hindrance to her integration. The strongest point was her dependency on Ms Hollins, and the grave consequences which might flow from breaking that link.

35. Overall, Ms Braganza submitted that the appellant's complex mental health needs amounted to exceptional circumstances. Removal was disproportionate on the facts, and the appeal should be allowed.

36. For the respondent, Ms Isherwood submitted that the *AM (Zimbabwe)* test was not met. The appellant arrived in the United Kingdom in 2008 with a number of medical issues for which she had received treatment there, and had continued to receive medical treatment in the United Kingdom for a number of issues. Ms Isherwood set out the new medical evidence summarised above. The appellant had cooperated with the medical professionals in the United Kingdom and could be expected to do the same in Trinidad and Tobago. She received support from her sister and son living in America, which could continue if she returned to Trinidad and Tobago.

37. Treatment was available in Trinidad and Tobago, notwithstanding the mistakes of the past. The appellant had life-saving operations in 2006, and free medical services were provided there. There was no evidence to support the appellant's subjective view that the medical care in Trinidad and Tobago lacked the expertise available in the United Kingdom. The appellant's medical conditions did not reach the Article 3 ECHR threshold.

38. Nor were there insurmountable obstacles to reintegration. Her elderly mother would be able to house her and remind her to take her medication, nor was there any reliable evidence that she would be mocked by the same, or different, individuals, if she returned now. Her private life was centred on her medical appointments and the treatment was available in Trinidad and Tobago. The appeal should be dismissed.

39. I reserved my decision, which I now give.

***AM (Zimbabwe)* and the *Paposhvili* test**

40. *AM (Zimbabwe)* in the Supreme Court, handed down on 29 April 2020, considered the effect of the decision of the Grand Chamber of the European Court of Human Rights in *Paposhvili v Belgium,* 41738/10 Chamber Judgment [2014] ECHR 431, [2017] Imm AR 867 on the United Kingdom jurisprudence, in particular at [32]-[34] in the opinion of Lord Wilson JSC, with whom Lady Hale JSC, Lady Black JSC, Lady Arden JSC and Lord Kitchin agreed:

> "32. The Grand Chamber's pronouncements in the *Paposhvili* case about the procedural requirements of article 3, summarised in para 23 above, can on no view be regarded as mere clarification of what the court had previously said; and we may expect that, when it gives judgment in the *Savran* case, the Grand Chamber will shed light on the extent of the requirements. Yet observations on them may even now be made with reasonable confidence. The basic principle is that, if you allege a breach of your rights, it is for you to establish it. But "Convention proceedings do not in all cases lend themselves to a rigorous application of [that] principle …": *DH v Czech Republic* (2008) 47 EHRR 3, para 179. It is clear that, in application to claims under article 3 to resist return by reference to ill-health, the Grand Chamber has indeed modified that principle. The threshold, set out in para 23(a) above, is for the applicant to adduce evidence "capable of demonstrating that there are substantial grounds for believing" that article 3 would be violated. It may make formidable intellectual demands on decision-makers who conclude that the evidence does not establish "substantial grounds" to have to proceed to consider whether nevertheless it is "capable of demonstrating" them. But, irrespective of the perhaps unnecessary complexity of the test, let no one imagine that it represents an undemanding threshold for an applicant to cross. For the requisite capacity of the evidence adduced by the applicant is to demonstrate "substantial" grounds for believing that it is a "very exceptional" case because of a "real" risk of subjection to "inhuman" treatment. All three parties accept that Sales LJ was correct, in para 16, to describe the threshold as an obligation on an applicant to raise a "prima facie case" of potential infringement of article 3. This means a case which, if not challenged or countered, would establish the infringement: see para 112 of a useful analysis in the Determination of the President of the Upper Tribunal and two of its senior judges in *AXB v Secretary of State for the Home Department* [2019] UKUT 397 (IAC). Indeed, as the tribunal proceeded to explain in para 123, the arrangements in the UK are such that the decisions whether the applicant has adduced evidence to the requisite standard and, if so, whether it has been successfully countered fall to be taken initially by the Secretary of State and, in the event of an appeal, again by the First-tier Tribunal.
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> 33. In the event that the applicant presents evidence to the standard addressed above, the returning state can seek to challenge or counter it in the manner helpfully outlined in the judgment in the Paposhvili case at paras 187 to 191 and summarised at para 23(b) to (e) above. The premise behind the guidance, surely reasonable, is that, while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving

state. What will most surprise the first-time reader of the Grand Chamber's judgment is the reference in para 187 to the suggested obligation on the returning state to dispel "any" doubts raised by the applicant's evidence. But, when the reader reaches para 191 and notes the reference, in precisely the same context, to "serious doubts", he will realise that "any" doubts in para 187 means any serious doubts. For proof, or in this case disproof, beyond all doubt is a concept rightly unknown to the Convention.

34. This court is not actively invited to decline to adopt the exposition of the effect of article 3 in relation to claims to resist return by reference to ill-health which the Grand Chamber conducted in the *Paposhvili* case. Although the Secretary of State commends the Court of Appeal's unduly narrow interpretation of the Grand Chamber's exposition, she makes no active submission that, in the event of a wider interpretation, we should decline to adopt it. Our refusal to follow a decision of the ECtHR, particularly of its Grand Chamber, is no longer regarded as, in effect, always inappropriate. But it remains, for well-rehearsed reasons, inappropriate save in highly unusual circumstances such as were considered in *R (Hallam) and R (Nealon) v Secretary of State for Justice (JUSTICE intervening)* [2019] UKSC 2, [2020] AC 279. In any event, however, there is no question of our refusing to follow the decision in the *Paposhvili* case. For it was 15 years ago, in the N case cited at para 2 above, that the House of Lords expressed concern that the restriction of article 3 to early death only when in prospect in the returning state appeared illogical: see para 17 above. In the light of the decision in the *Paposhvili* case, it is from the decision of the House of Lords in the N case that we should today depart."

41. The judgment of the European Court of Human Rights in *Savran* was a divided one, with four of the judges dissenting. The majority held that, the applicant having raised a prima facie case of Article 3 ECHR violation on return, it would be disproportionate to remove the appellant 'without the Danish authorities [the host country] having obtained, in accordance with that provision, individual and sufficient assurances that appropriate treatment would be available and accessible to the applicant on return'. The majority judgment explained its conclusion thus:

"60. On the one hand, the Court reiterates that, when verifying whether the care generally available in the receiving State is sufficient and appropriate in practice for the treatment of the applicant's illness so as to prevent him or her being exposed to treatment contrary to Article 3, the benchmark is not the level of care existing in the returning State. It is not a question of ascertaining whether the care in the receiving State would be equivalent or inferior to that provided by the health-care system in the returning State (see paragraph 46 above). Rather, the question is whether the applicant, if he were not be able to receive "appropriate" treatment in Turkey, would be exposed to a serious, rapid and irreversible decline in his state of health, resulting in intense suffering (see paragraph 45 above).

61. On the other hand, in the light of the above statements by Consultant Psychiatrists K.A. and P.L., insisting on the necessity of follow-up and control in connection with intensive outpatient therapy, the Court finds it noteworthy that the High Court, in contrast to the City Court, did not develop on this issue.

62. The Court reiterates that the existence of a social and family network is also one of the important elements to take into account when assessing whether an individual

> has access to medical treatment in practice (see *Paposhvili*, cited above, § 190). In the present case, the applicant maintained that he had no family or other social network in Turkey. On this particular point the present case has similarities with *Aswat v. the United Kingdom* (no. 17299/12 , § 57, 16 April 2013), and can be distinguished from, for example, *Bensaid* (cited above § 20) and *Tatar* (cited above, § 12).
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> 63. Although recognising that there is no medical information in the present case pointing to the importance of a family network as part of the applicant's treatment, the Court cannot ignore that the applicant is suffering from a serious and long-term mental illness, paranoid schizophrenia, and permanently needs medical and psychiatric treatment. Returning him to Turkey, where he has no family or other social network, will unavoidably cause him additional hardship, and make it even more crucial, in the Court's view, that he will be provided with the necessary follow-up and control in connection with intensive outpatient therapy upon return. It reiterates in this respect, *inter alia*, that according to the psychiatric reports (see, in particular, paragraphs 19, 22, and 58 above) the applicant has been prescribed complex treatment and the treatment plan has to be carefully followed. Antipsychotic medication must be administered on a daily basis, which was deemed to constitute a risk of pharmaceutical failure and consequently the worsening of the applicant's psychotic symptoms and a greater risk of aggressive behaviour.
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> 64. Therefore, a follow-up and control scheme is essential for the applicant's psychological outpatient therapy and for the prevention of a degeneration of his immune system. For that purpose he would need, at least, assistance in the form of a regular and personal contact person. Accordingly, in the Court's view, the Danish authorities should have assured themselves that upon return to Turkey, a regular and personal contact person would be available, offered by the Turkish authorities, suitable to the applicant's needs."

42. That is the roadmap against which the present appellant's factual situation falls to be considered.

Analysis

43. The medical evidence set out above discloses a significant and steady deterioration in the appellant's mental and physical health since she arrived in the United Kingdom. She lacks confidence in medical treatment in Trinidad and Tobago, because of the treatment she received originally, and that will contribute to the enhanced risk of suicide which Dr Sridharan and his CPN, Ms Hollins, have both recorded as their opinion. There is no reason to distrust the evidence of Dr Sridharan and Ms Hollins, who are jointly closely involved in the appellant's care. I am satisfied that a prima facie case for a breach of Article 3 ECHR has been made out, given her lack of family network, her near blindness, her repeated attempts at suicide and her hostile hallucinations, her scarred appearance, her cognitive difficulties and her increasing memory loss.

44. As regards Article 3 ECHR, it is right to say that the appellant's having obtained treatment while in the United Kingdom without leave, and her return to Trinidad and Tobago in 2005, are not relevant in considering whether she is entitled to Article 3 ECHR protection. The Secretary of State has not brought before the Upper Tribunal

evidence which shows on an individual basis that there are effective measures to support the appellant on return, to avoid a 'serious, rapid and irreversible decline in her state of health, resulting in intense suffering'.

45. The generic evidence that free treatment is available in Trinidad and Tobago is not sufficient to discharge the burden on the Secretary of State and it does not amount to 'individual and sufficient assurances that appropriate treatment would be available and accessible to the applicant on return'.

46. On the evidence before me, this appellant has demonstrated that there are 'very significant obstacles' to her reintegration in Trinidad and Tobago on return. Even in the United Kingdom, the appellant finds integration difficult and she is strongly bonded to Ms Hollins. Even if the appellant cannot bring herself within the Rules, I am satisfied that her level of accelerating disability amounts to exceptional circumstances for which leave to remain should be granted outside the Rules.

47. For all of the above reasons, this appeal is allowed.

DECISION

48. For the foregoing reasons, my decision is as follows:

The making of the previous decision involved the making of an error on a point of law. I set aside the previous decision. I remake the decision by allowing the appeal.

Signed *Judith AJC Gleeson* Date: 7 January 2021
Upper Tribunal Judge Gleeson