IAC-FH-CK/SC-V1

Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: PA/03329/2016**
('V')

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
And via Teams	**On 09th March 2022**
On 26th January 2022	

Before

UPPER TRIBUNAL JUDGE L SMITH
UPPER TRIBUNAL JUDGE KEITH

Between

AMA (SOMALIA)
(ANONYMITY DIRECTION CONTINUED)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Direction Regarding Anonymity – Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008

Unless and until a Tribunal or court directs otherwise, the appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him or any member of his family. Failure to comply with this direction could lead to contempt of court proceedings.

Representation:
For the Appellant: David Chirico, Counsel, instructed by TRP Solicitors
For the Respondent: Stephen Whitwell, Senior Home Office Presenting Officer

DECISION AND REASONS

1) This is the remaking of the decision in the appellant's appeal against the respondent's refusal of his protection claim. Our error of law decision is appended hereto for ease of reference.

2) The hearing was conducted as a hybrid hearing. Mr Whitwell attended in person, as he had previously experienced difficulties with his link to Teams, while Mr Chirico attended remotely. We were satisfied that both representatives were able to participate effectively in the hybrid hearing, which involved legal submissions only. These included detailed written submissions.

3) The sole issue in dispute between the parties, was whether the appellant had rebutted the statutory presumption under Section 72 of the Nationality, Immigration and Asylum Act 2002 that he was a "serious criminal", having been convicted of two particularly serious crimes, namely with periods of imprisonment of at least two years. The two index offences were of rape, of which he was convicted on 1st May 1995 at Bristol Crown Court and sentenced to 30 months' imprisonment; and unlawful wounding, of which he was convicted on 15th March 2000 at Middlesex Guildhall Crown Court and sentenced to five years' imprisonment, reduced to 42 months' on appeal. The appellant's wider offending is something we deal with later in this decision, including offences for which the appellant has not been prosecuted because instead he has been the subject of mental health detentions and treatment.

4) The appellant accepts that both crimes were particularly serious, for the purpose of Section 72(2). The sole question remains whether the appellant constitutes a danger to the community of the United Kingdom. The issues in dispute were previously wider, but the respondent now accepts that absent the certification under Section 72, the appellant has a well-founded fear of persecution, based on findings by a Judge of the First-tier Tribunal, Judge Monson, in his decision promulgated on 14th January 2019. As per §74 of Judge Monson's decision, this was not on the basis that there was an absence of suitable treatment for the appellant's paranoid schizophrenia in his country of origin Somalia, but the risk that his condition would lead to him suffering inhuman and degrading treatment. That treatment was being enchained; or, if not restrained by chains and allowed to roam the streets in Mogadishu in a dangerous psychotic state, the risk that he would simply be shot dead by armed soldiers. Mr Clarke, Senior Home Office Presenting Officer, conceded the persecution risk at an earlier hearing before this Tribunal on 11th October 2021, on the basis of membership of a "particular social group", as per DH (Particular Social Group: Mental Health) Afghanistan [2020] UKUT 00223 (IAC).

5) In that same hearing, Mr Clarke pointed out that the most recent medical evidence was well over a year old and pre-dated the Covid pandemic. Mr Chirico, who appeared in the same hearing, indicated that the appellant had recently had a brief relapse in his mental ill health. As a consequence, the appellant was given the opportunity to adduce further updated

medical evidence. The appellant relies on five medical reports of Dr Anna Preston, consultant clinical psychologist, dated 28th November 2018; 2nd January 2020; 18th February 2020; 17th December 2021; and 26th January 2022. For convenience, we refer to them as the first report, the second report etc. The representatives also relied upon original and supplementary skeleton arguments, which we have considered in full. We do not recite these in full but refer to them where necessary. We also refer to the respondent's decision letter dated 21st March 2016 at pages [51] to [74] of the appellant's bundle ("AB"). The salient points of that refusal decision, other than to recite the appellant's extensive immigration and offending history, were that the respondent had considered the appellant's submission that his index offences had been committed fifteen and twenty years ago and were in the context of his mental ill-health. In maintaining that he was a danger to the community of the UK, the respondent had pointed out at §67, that in July 2015, the appellant had been once again arrested by the police on suspicion of affray and placed on police bail. Despite the appellant's acknowledged treatment for his mental health, the refusal letter referred to a continued risk of reoffending (§68).

Dr Preston's reports

6) We turn to passages of Dr Preston's reports. To the extent that the reports cite facts, we adopt them as findings, as they are undisputed. Where Dr Preston provides an opinion, that is the subject of further discussion later in these reasons. It is necessary to cite more passages from these reports than is perhaps common, because of the extensive and complex history of events. We pay tribute to the clarity of the reports, which has assisted us greatly.

7) In the first report, at [AB/86], Dr Preston summarises her findings at §§1.1 to 1.6. By reference to relevant diagnostic criteria, in 2018, she assesses the appellant as presenting a high risk of general reoffending, but this general risk was inflated by various static and historic criteria. Instead, she assesses him as presenting a moderate risk of general (non-violent) re-offending, and a low risk of future violent reoffending at the current time. There were a moderate to high number of "protective" factors, i.e., those which mitigated the danger posed by the appellant.

8) Dr Preston next discusses the appellant's immigration and criminal history, at §3.2, [AB/88] to [AB/93] . The appellant, a Somali national born on 20th January 1966, grew up in Somalia and married there. He moved to Kenya in 1992. He may have contracted HIV there, having visited prostitutes. He experienced his first psychotic breakdown in 1993 and received psychiatric treatment in Kenya. Family members, including his mother and brother, have also experienced mental ill-health. The appellant has received numerous medical diagnoses, including of paranoid schizophrenia; drug induced psychotic illness; post-traumatic stress disorder; organic mental disorder; harmful use of khat, cannabis and alcohol; and a dissocial personality disorder. At §3.2, she continues:

"3.2.4 [AMA] is reported to have travelled to the UK in 1994 with an uncle from Kenya. Home Office documentation indicates that he arrived in the UK on 22nd January 1994 and claimed asylum at port. His asylum claim was refused on 11th February 1994 and he was granted exceptional leave to remain.

3.2.5 In May 1997 he was assessed by UK Mental Health Services in Bristol after exhibiting paranoid ideation and isolating himself. A diagnosis of paranoid schizophrenia was made. It was considered that his mental health condition was caused by his use of khat. He came to the attention of psychiatric services in London in December 1997 when he was admitted as an informal patient (i.e. not under the mental health section) after reporting auditory hallucinations. His psychotic treatments responded quickly to treatment and he was discharged in January 1998. His third admission took place in 1998 when he was once again presenting as agitated and paranoid. His symptoms rapidly subsided with antipsychotic medication.

3.2.6 [AMA] has an extensive forensic history that dates back to 1995, after the onset of his contact with mental health services. On 1st May 1995, he was convicted of rape at Bristol Crown Court and sentenced to 30 months' imprisonment. No details appear to be available regarding the offence of rape. [AMA] reported that the offence was committed against a prostitute. He stated, "She tried to rip me off and take my money. I was drinking with my cousin and he said let's get a prostitute and we saw two prostitutes in Bristol. They started taking the piss and one started smoking my weed. We had sex and then she wanted to rob me of all my money. She is an evil woman. I didn't rape her. She put me into trouble for no good reason. I am a good man. I didn't want to hurt anyone." [AMA] became distressed and agitated as he recalled the offence. He denies raping the woman, suggesting that the sex was consensual although appears to hold residual feelings of anger towards the woman for wanting to take his money in exchange for sexual intercourse.

3.2.7 In July 1997 he received a conviction for failing to surrender to custody and in October 1997 he was convicted of theft. In 1998 he was convicted for dodging a railway fare and received a conditional discharge. In August 1998 he was arrested for assault. In November 1998 he was arrested for failing to appear at Marylebone Magistrates' Court and for causing two thousand pounds' worth of criminal damage to the offices of Westminster Housing Authority. In July 1999 he was arrested for being drunk and disorderly and suspicion of theft and wounding with intent to cause GBH. In March 2000 he was convicted of wounding at Middlesex Guildhall Crown Court and received a five year prison sentence varied on appeal to 42 months. It is reported that during an argument with a Somali drinking companion and with both males under the influence of drugs, [AMA] stabbed his companion. In 2000 to 2001 he received psychiatric treatment ….

3.2.8 In February 1998, [AMA] visiting a housing office in Bermondsey and requested a move to Southall. When this was declined, he smashed 15 windows at the hostel where he lived. He was also violent and smashed a telephone box in the street and was charged and taken

into police custody. A diagnosis of khat abuse and possibly PTSD was made. [AMA's] fourth admission to psychiatric services occurred in February to April 1998 when he was admitted to the Maudsley Hospital under Section 2 of the MHA. He was detained under Section 136 by the police for breach of the peace and bizarre behaviour. He reported experiencing auditory hallucinations, was unkept, restless, agitated and had pressure of speech and loosening of associations. He also displayed aggressive behaviour and was referred to the Spur hostel for alcohol and anger issues. He was evicted for getting into fights, making hoax phone calls to the police and ambulance services and was transferred back to the Maudsley Hospital.

3.2.9 [AMA] was diagnosed as HIV positive on 6th April 1998. After discharging himself against hospital advice, a diagnosis of unspecified mental disorder due to brain damage and dysfunction and physical disease was made and he was referred to the local CMHT but had left London and was living with his sister in Bristol. In 1999 he was admitted to hospital in Bristol under Section 37 (Mental Health Act 1983) after being transferred from HMP Brixton with a diagnosis of drug induced psychosis and antisocial personality disorder.

3.2.10 A further hospital admission followed in July 1999. In August 1999, [AMA] was arrested and charged with wounding with intent. It is reported that whilst in prison he made suicide attempts and threats to staff. In March 2000 he was convicted of GBH and sentenced to five years' in prison. Repeated suicide attempts in prison resulted in his transfer to hospital. In 2001 he was diagnosed with dissocial personality disorder and a mental and behavioural disorder due to use of alcohol and khat. ….

3.2.12 I understand that [AMA] was later convicted of affray and criminal damage on 12th October 2010 at Leicester Crown Court and sentenced to 12 months' imprisonment. He was discharged in 2010. He had a further inpatient admission when living in Leicester after his friend called the police to report that [AMA] was hearing voices telling him to kill himself. He presented in a threatening manner towards staff and patients and there were allegations made that he was trying to sell drugs on the ward. He was arrested by police in 2011 after displaying threatening behaviour at an inpatient unit in Leicester.

3.2.13 In May 2011 he was discharged from the community team as it was not considered possible to effectively manage his condition in the community or mitigate the risk to self or others. [AMA] was reported to have a history of carrying knives and offensive weapons.

3.2.14 During detention at HMP Ranby, [AMA] was restarted on antipsychotic medication in February 2011. On 3rd June 2011 a diagnosis of dissocial personality disorder was made and transfer to hospital was recommended. … He was discharged from prison in September 2012 and housed in Harringay. … In October 2012 an urgent MHA assessment was requested after [AMA] began expressing paranoid thoughts and on 18th October 2012 he was referred to the forensic community team. He spoke of stabbing

others he believed were trying to harm him and admitted to intermittently carrying a knife.

3.2.15 In November 2012 he was reviewed and found to be relatively stable but this was short-lived and in December 2012 he was seen at home and found to be paranoid and likely experiencing auditory hallucinations. … On 16th February 2013, [AMA] presented to St Ann's Hospital, heavily intoxicated with alcohol and displaying threatening and abusive behaviour, punching windows. He reported that he had been arrested for common assault. In April 2013 he was having thoughts of taking his own life and had gone to London Bridge with intentions of jumping in the river.

3.2.16 [AMA] has a long history of drug and alcohol misuse. … There is a history of aggressive and violent behaviour when under the influence of alcohol. [AMA] used khat from the age of 16 years and in 2001 he reported intermittent use of cannabis for a period of approximately three years.

3.2.17 When assessed in … 2013 [AMA] was considered as presenting a moderate risk to self, a high risk to others and a low risk from others … and a high risk of disengagement from services. A diagnosis [was made] of paranoid schizophrenia…. [It] was considered that absence from alcohol and drugs was essential for [AMA] to be safely managed in the community.

3.2.18 AMA was given an appointment with a forensic team on 3rd December 2013 but he failed to attend. He cancelled an appointment on 9th January 2014. When spoken to he described feelings of frustration and stress at having a tag that he perceived was preventing him from going swimming as he would be embarrassed for people to see the tag. He reported that being subject to the tag was affecting his mental health.

3.2.19 [AMA] had refused to consider depot medication when reviewed in January 2014; his engagement with Mental Health Services was sporadic and due to his refusal to consider depot medication there was no reliable means of monitoring his level of risk…. He denied drinking or using drugs, describing his mental health as "alright" and appeared to be stable and he reported compliance with medication although he was suspected of being non-compliant with medication.

3.2.20 NHS entries in 2014 suggest some non-compliance with attending appointments with the mental health team. When he was seen there was no evidence of effective, thought or perceptual disturbance. He is recorded as having made a threat to stab someone if made to move out of Haringey and into a shared flat with anyone although [AMA] denied making an explicit threat. It was considered that he could present a serious risk to others if moved into shared accommodation.

3.2.21 In August 2014 he had reported that he was attending the gym every other day and avoiding all thoughts or voices telling him to carry a knife. He remained anxious about his tag. He was able to describe early indicators of relapse into his illness and reported that he would go to hospital or call his care team if he starts experiencing paranoid beliefs, voices an urge to carry knives or thoughts about harming himself. He denied use of illicit substances.

3.2.23 From May to December 2015 [AMA] is reported to have consistently breached his tagging curfew, failing to allow officers to access his property and did not report to a Home Office reporting centre on a regular basis.

3.2.24 ... [AMA] is reported to have exhibited depressive preoccupations regarding his tag, described anxieties when he sees people looking at him and reported poor appetite with associated weight loss and loss of enjoyment in food. His sleep was reasonable. No psychotic phenomena were observed or reported. [The doctor] reported that in his opinion, [AMA] suffers from chronic paranoid schizophrenia (considered to be in remission in June 2015). Relations with his psychiatric team were good and this and [AMA's] cooperation with medication were both crucial aspects of his psychiatric care and condition. He also considered that [AMA] had some real insight into his mental health condition and need to take medication. [The doctor] opined that if unable to access medication, [AMA] would rapidly relapse with a resurgence of psychotic symptoms and an associated decrease in his ability to look after himself and an increase in his risk of harm to self.

3.2.25 In July 2015 [AMA] was arrested on suspicion of affray and bailed until October 2015. On 18th September 2015 he was sectioned under the Mental Health Act... He was discharged on 11th November 2015. On 24th November 2015 Section 4 support was withdrawn [i.e. for support for refused asylum seekers], given [AMA's] failure to report, failure to be at his authorised accommodation during curfew hours and failure to use funds available on his Azure card. Support was reinstated on 30th November 2015 as [AMA] had begun reporting again. [AMA] was arrested on 23rd February 2016 but no further action was taken.

3.2.26 [AMA] had further admissions to psychiatric hospital on the following dates: 17th August 2016, 7th September 2016 and 24th September 2016. Admissions typically followed a period where [AMA] was not taking his medication as prescribed, was using alcohol (up to 30 units per day), and was experiencing symptoms of psychosis (paranoia, hearing voices). On 24th September 2016 he threatened to kill his neighbour, and subsequently reported that the "voices" has told him to do it.

3.2.19 In his report, [Associate Specialist, Rehabilitation Team] states the following: [AMA's] mental state is stable. The primary reasons for his present, relative stability are the health intervention in the form of regular monitoring of his mental health and treatment for psychiatric medication in addition to the social intervention in the form of placement in 24 hours monitored and supported accommodation. He is monitored 24 hours by staff at his supported accommodation, every fortnight by his care coordinator and community psychiatric nurse and every three months by myself ... [AMA's] current risk to self and others has been managed by regular psychiatric input and social intervention he has been receiving. If [AMA] is not in receipt of both psychiatric input and social intervention, he is very likely to relapse into a psychotic state. His lengthy history of mental ill-health clearly confirms this. This risk

> will manifest itself in increased risk to himself and aggression to others. The risk will be a high one."

9) Dr Preston then describes the appellant's support network of a sister who lives in Milton Keynes, an aunt who lives in Bethnal Green, cousins in Bristol and a former wife who lives in Birmingham. [AMA] also described having a number of friends but not ones with whom he had talked about personal feelings or matters.

10) Under the standard diagnostic criteria, the appellant had a "high level of general offending risk" (§4.2, [AB/98]) as a result of his criminal history, his education history and lack of employment, and previous use of alcohol and cannabis, bearing in mind that his reported abstinence was relatively recent. There was no evidence to support the presence of pro-criminal orientation but there was an "antisocial pattern" including a past diagnosis of dissocial personality disorder and generalised trouble as evidenced by lack of stable employment, financial concerns, lack of higher education and non-rewarding parental relationship. However, at §4.3, Dr Preston regards this diagnostic assessment as inflated by the appellant's lack of engagement in work. She assesses the risk of general non-violent offending as moderate rather than high. Dr Preston assesses the risk posed by the appellant of future violent reoffending as low, (§ 5.4.1, [AB/103]) based on him living in supported accommodation, taking medication as prescribed and abstinence from drugs and alcohol. Should he not have access to that support, take his medication or relapse into substance abuse, the risk of his violent reoffending would rapidly increase to high. Dr Preston describes the protective factors as his current abstinence from drug and alcohol use; a capacity for awareness of the impact of his offending on others; and his regular gym attendance.

11) Dr Preston's second report, at [AB/116] to [AB/149], followed her clinical assessment of the appellant on 25th November 2019. Her summary, at §1.7, [AB/119], is that the appellant presents a low risk of violent reoffending, but this would increase to high if he experienced a combination of the following together: if he stops taking his medication; if he does not have access to any support in order to address this quickly; and if he relapses into alcohol or drug use. Deterioration of the appellant's mental health is said to be the most critical risk factor for the appellant. The appellant is described as not presenting a significant risk of serious harm to the public and on the contrary, he presented as motivated to help others.

12) Dr Preston describes his current circumstances as living in 24/7 supported accommodation in London, with plans to remain there for one year, after which his mental health team would consider him moving him to a one-bedroom flat due to his positive progress (§3.3.2, [AB/127]). Dr Preston records at §3.3.4 that the appellant denied any relapse in psychotic symptoms since she last assessed him. While he described experiencing mild paranoia, such as thinking people on the bus "know his business" he

managed this effectively and had insight that these were related to his psychosis; were distorted and untrue.

13) While we have considered Dr Preston's third report of 18th February 2020, it followed on swiftly from the second report of 2nd January 2020 and was in response to further specific questions from the appellant's solicitors. For the sake of brevity, we do not recite its contents. Instead, we move on to Dr Preston's fourth report, dated 17th December 2021 starts at page [2] of the appellant's supplementary bundle (ASB). It followed a further relapse in the appellant's drug use. Dr Preston's updated risk assessment, at §§1.2 to 1.7 is as follows:

> "1.2. Assessment … indicates a high level of risk for general offending. However, it is important to highlight that [AMA's] risk on this assessment is inflated by his lack of engagement in employment with four automatically assigned points for being out of employment at the time of assessment; the majority of items that he scores on are static and historical and [AMA] has made significant changes over time. Therefore, the [assessment] is limited in its meaningful predictive ability for offending. In my clinical opinion, based on current assessment of [AMA], his risk of general (non-violent) offending now falls in the low range. To his credit, [AMA] has not received any criminal convictions since 2010.
>
> 1.3. … A structured assessment of the risk of violence, indicates a low risk of future violent reoffending at the current time. It is notable that even in the context of mental health decline and cannabis use, [AMA] did not present with offending behaviour outside that of the use of cannabis. There was no violence towards others despite increased paranoid ideation, and [AMA] was able to recognise the changes in his mental state, the impact of cannabis use, and took action to seek help. Therefore, this indicates that substance use and mental health relapse will not inevitably lead to increased reoffending risk, and that [AMA] can recognise signs and take appropriate action to prevent escalation.
>
> 1.4. Risk of reoffending may increase to moderate where mental health and substance use relapse occurs in the context of having no access to personal or professional support. That said, it is unlikely that [AMA] would be in the position where he has no access to such supports, as his networks are well-established and his relationships with sources of support are good. To his credit, [AMA] is highly motivated to remain compliant with his medication and the negative impact of his most recent cannabis use has re-confirmed to him the need to remain abstinent from substances. His level of engagement in programmes related to his holistic needs is substantial and his positive life goals and his motivation to achieve them are significant. He remains in contact with his CMHT, and the reduction in level of professional support is indicative of a reduced concern regarding mental health and risk and is also reflected in his increasing self-management with regards to his medication.
>
> 1.5. Early warnings signs for [AMA]'s risk include significant increase in paranoid ideation, social withdrawal, disengagement in sports and leisure activities, self-isolating behaviours, self-neglect, loss of

appetite, lack of sleep, unkempt appearance, use of substances, reporting the experience of auditory hallucinations or when observed to be responding to external stimuli, non-compliance with medication, restless or agitated presentation with pressure of speech or flight of ideas, persecutory remarks and expressing a perceived need to defend or protect himself and carrying knives upon his person.

1.6. Assessment using the [standardised assessment – "SAPROF"] indicates that there are a high number of protective factors present at the current time that reduce the risk presented by [AMA]. There is the presence of internal protective factors including empathy, coping and self-control, despite a period of relapse which he sought help for and escalation was prevented. There are motivational factors in respect of his compliance with medication, motivation to address his mental health, attitude towards authority, ability for financial management, realistic life goals and development of leisure activity. There is the presence of external factors in terms of the professional care he can access from mental health services and from support at his accommodation. He is happy with his new residence, and has a wide social network through engagement in meaningful activity and exercise. Should he have the opportunity to engage with the training and subsequent employment he has the motivation to do, this would enable a further protective factor for him with regards to both his mental health, and risk of reoffending.

1.7. In conclusion, it is my opinion that [AMA] presents a low risk of violent reoffending, a low risk of general reoffending (aside from moderate risk of using cannabis, specifically) and a low risk of causing serious harm to the public, if allowed to remain in the UK.

14) At §2.1.2, ([ASB/6]) Dr Preston describes the appellant as previously presenting a low risk of violent offending and moderate risk of non-violent offending, contingent upon his mental health being stable and refraining from drug use. He had received no further criminal convictions but had returned to a period of cannabis use and instability in his mental health, which led him to self-referring to his GP, reported worsening of his paranoid thoughts. Dr Preston discussed the appellant's relapse in January 2021 further at §3.3.2, 3.3.6; and 3.37, [ASB/14-15]:

"3.3.2 There was a relapse in [AMA]'s mental health in January 2021 when he then self-referred to his GP with a worsening of paranoid symptoms. He had been using cannabis, and regular care co-ordinator contact had ceased due to COVID-19. He said "The contact continued by phone. But if there was something serious then they would come and see you; so I saw the care co-ordinator when I moved house." [AMA] spoke about his mental health relapse in January 2021. He said "I felt so depressed because of the [COVID-19] virus. I had nothing to do, and I don't drink. I couldn't go out and there were restrictions where I live; nobody could visit me or see me. I couldn't go out as I am high risk for COVID-19 and the gym was shut. I was so bored. I started smoking weed, then was so depressed, smoking again, then got help. I called hospital and told them, they came to help me and put me in touch with a telephone drugs advisor to help me stop. I used those strategies to cut down.

3.3.6. … [AMA] emphasises the importance of taking his medication "otherwise I don't sleep well, get paranoid and don't go out." His medical records show he was seen in January 2021 and reported hearing shouting voices and seeing pictures on the wall. During the current interview, [AMA] spoke about his experience in January 2021 of hearing shouting voices. He said "It felt like my head was full of noise. It was scary. I was paranoid and was seeing flashes. The voices were speaking, putting me down, saying 'You are nothing'. I felt like everyone knew my business."

3.3.7. [AMA] was seen by the Home Treatment Team (HTT) in February 2021. He had been referred to by The Grove after a telephone session he had with staff, during which he reported hearing voices telling him to carry a knife and stab someone, believing that people were out to get him. During interview on 2nd December 2021, [AMA] said it was the case that when unwell, he believed people were laughing at him or wanted to cause him harm. He admitted that he had previously heard voices telling him to jump in front of a moving car, which he had reported to staff, but stated that these had been historical rather than linked with his most recent relapse. His medical records stated that when seen on 24th February 2021, HTT staff spoke with the manager at [AMA's] accommodation and they reported him presenting as his usual self, with no concerns about change in presentation, no deterioration, and questioned the need for the HTT. They indicated that some level of self-neglect and reporting of hallucinations was in line with his usual 'baseline' presentation and that he needed to work with the Grove as the main concern was cannabis use. They highlighted that he had made several requests for a care co-ordinator but stated this was not required and that he was very functional. Personality and antisocial behaviour traits, bullying of his peers, and making threats had been observed. He was seen by the HTT, was pleasant and engaged but with poor self-care and the smell of cannabis in his room. He was frustrated that he was not being allocated a care co-ordinator. He agreed to work with staff at The Grove, and be discharged from HTT. In June 2021 he was re-referred to the community substance misuse team. A mental health review indicated no change in mood, he was feeling better, with no experience of hallucinations. He agreed he would benefit from counselling for cannabis use and expressed a motivation to stop using. There was no evidence of suicidal ideation."

15) At §3.3.9, [ASB/16], Dr Preston notes that at the date of her assessment in December 2021, the appellant had been prevented from going to the gym because of the Covid pandemic but planned to return in the near future. At §3.3.12 ([ASB/17]) she described his social network:

"3.3.12 [AMA] said he feels supported by his social network, and also said he can make contact with his mental health team and care co-ordinator at any time. He also stated that although staff are on site at his current residence between 9am and 5pm, there is a member of staff available 24/7 should they be needed, as outside of those hours, they are employed to stay in a property next to the main house. He knows the staff who alternate their shifts in this role, and added, "Anything you need, they come." Therefore, the level of support

available has reduced when compared to his previous residence. With regards to medication management, he was administered his medication every day by staff but is now provided with his medication for the week and self-manages this. He said, "I feel better about this, and more responsible."

16) In her assessment the risk of general offending, Dr Preston adds at §4.4, [ASB/19], notwithstanding his recent mental health relapse, this does not necessarily mean entering a pattern of reoffending, as the appellant had refrained from criminal activity for a prolonged period of time. The risk of committing non-violent offences was low, rather than medium.

17) Finally, in response to criticisms of her first four reports by the respondent in initial submissions, Dr Preston produced a fifth and final report on 26th January 2022. We note in particular the respondent's criticisms, quoted at §2.1, [AB/61] and Dr Preston's response at §2.1.1:

> **"2.1. It is submitted there are a number of problems with the expert's conclusions as set out @14 above. First, UTJ Reeds @109 characterised behaviour that could [AMA] be construed as a danger to the community as including: threatening, abusive intimidating behaviour towards others, as identified in the medical reports, a history of carrying knives and violence and threats of violence. It is evident from the chronology in the expert report that behaviour after 2010 will necessarily fall into these categories. In addition, [AMA] has also expressed during this period further thoughts of harming others. It is therefore surprising that the expert appears to downplay this conduct @1.2 and 7.9. In particular @7.9 the expert states, "[AMA] has not received any criminal convictions since 2010. Eleven years being conviction free suggests {AMA] developed skills in self control and emotional management." It is respectfully submitted that this statement is in direct tension with [AMA's] recorded behaviour, which included threats with a knife in 2016. The expert fails to explain what self-control was present at the material times after 2010. It is submitted that this statement casts doubt upon the expert's understanding of dangerous conduct and the presence of protective factors when ascertaining risk.**
>
> 2.1.1. In response to the point raised above, I confirm I have taken into account the threats made with a knife in 2016. [AMA] has not presented with a pattern of such behaviour despite facing numerous life stressors, as set out in my report. This indicates that [AMA] has developed skills in self-control and emotional management, especially when compared with previous behaviour. This cannot be dismissed and therefore, the protective factor (stated as 'partially present') of self-control is still accurate. It is also important to note that in conducting accurate risk assessment, the dynamic (i.e. changeable) nature of some risk factors must be taken into account; the threats made with a knife occurred in 2016 and are therefore more than 5 years prior to my most recent assessment of [AMA]"

THE PARTIES' SUBMISSIONS

The Appellant's Submissions

18) We summarise the gist of Mr Chirico's submissions on behalf of the appellant, including his two skeleton arguments and oral submissions.

19) First, the appellant did not pose a real risk so as to constitute a danger to the community of the UK. Second, if we concluded that he did present a risk of re-offending, the likelihood was that any acts would be managed with medical treatment relating to his mental health, rather than prosecution, as he lacked the necessary criminal intent. There was no reason to suppose that the appellant would not continue to cooperate with his doctors and accommodation staff, and he was highly motivated to continue to take his medication, so that on a practical level, any danger would be mitigated. This reflected Dr Preston's assessment that he constituted a low risk of offending, both violent and non-violent. The risk of drug use was higher (moderate), but it was never suggested that any offence of drug use satisfied the statutory test of "danger to the community" in Section 72. Any reduction in his medical and other support would be carefully managed.

20) Article 33(2) of the Refugee Convention, which Section 72 of the 2002 Act seeks to implement, made clear that the relevant "danger" should be assessed in the context of the appellant's previous convictions for particularly serious crimes. The present danger must also be assessed by reference to any future conduct, which would lead to a criminal conviction. The danger posed was of a low risk of future violent reoffending and general reoffending. Despite the appellant's recent relapse into drug use, it had not resulted in any violence towards others, despite his increased paranoia. This was because the appellant had been able to recognise the changes in his mental health. It was unlikely that the appellant would lack a support network. His network was well-established, as he was undergoing long-standing medical treatment, had an established family network and accommodation arranged for him. Those in the appellant's support network had managed the risk posed by the appellant's drug use. It was not permissible (and not realistic) to discount the availability of medical and welfare support (including assisted accommodation) to the appellant when that support had been consistently provided over many years. The appellant's current circumstances were in stark contrast to the period during the 1990s when the appellant's most serious index offence occurred, and his behaviour was largely unregulated.

21) Mr Chirico emphasised the importance, when considering danger, of the distinction between serious violence and less serious threats. The question was whether the respondent had shown that the appellant posed a sufficient risk of offending in a sufficiently serious way, so as to constitute a relevant danger. Context was all-important to the assessment of that risk. The risk had to attain a certain level of seriousness. It had never been contended that the 2010 affray conviction

was sufficiently serious. We explored with Mr Chirico whether the appellant might constitute a danger, even if the risk were low, if the consequences of that risk crystalising were sufficiently serious. Mr Chirico accepted that there might, in theory, be such cases, and the more serious the consequences, the lower the risk of repetition or occurrence needed to be. However, even taking the hypothetical case of a risk that a person might kill another, the person might still not constitute a danger if the risk was sufficiently mitigated.

22) Danger did not import a different test of proportionality or justification. This was because the consequences of certification were potentially so serious. The starting point of Section 72 was that someone had committed a particularly serious crime. In relation to the suggestion that the danger was not defined in Section 72 as needing to be a conviction for another offence, and that behaviour which resulted in medical treatment, rather than prosecution, might amount to a danger, Mr Chirico argued that the respondent had not identified any danger other than the commission of further offences of which the appellant was convicted.

23) Mr Chirico accepted that at §§39 to 46 of the judgment in EN (Serbia) v SSHD [2009] EWCA Civ 630, Stanley Burton LJ had rejected the proposition that there needed to be a causal connection between the particularly serious crime (the first limb of Section 72) and the danger which the serious criminal posed. However, the Court in that case had accepted that normally, the danger would be demonstrated by risk of recurrence of the particularly serious crime. While there did not need to be a causal connection, there needed to be some kind of link, which reflected Stanley Burton LJ's reference to the example of disregard for the law, at §46. Moreover, as reflected in §66 of EN (Serbia), a person may have been convicted of a particularly serious crime but because of mitigating factors associated with its commission or because of the absence of a danger of repetition, he might not constitute a danger to the community. Indeed, Section 72 was only regarded as consistent with Article 33(2) because the statutory presumption in Section 72 was rebuttable. In the appellant's case, the mitigating factors were substantial. They included the appellant's support network; his medical treatment; and his insight into the effects of his offending.

24) Mr Chirico submitted that the other authorities relied upon by the respondent did not assist in this case. The decision of Restivo (EEA – prison transfer) [2016] UKUT 00449 (IAC) supported the proposition that in assessing a sufficiently serious threat for the purposes of the Immigration (EEA) Regulations 2006, the fact that such threat is managed while that person serves their prison sentence is not itself material to the assessment of the threat he or she poses. The threat exists, whether or not it cannot generate further offending simply because the person concerned, being imprisoned, has significantly less opportunity to commit further criminal offences. The appellant's circumstances, where he received ongoing and substantial mental health and social support, without which he might offend, were not analogous to imprisonment. The

result of that logic would mean to disregard entirely the appellant's mental health support. The authorities of Chege ("is a persistent offender") [2016] UKUT 00187 (IAC) and Binbuga (Turkey) v SSHD [2019] EWCA Civ 551 did not take matters further. While there was discussion in that case of what was meant by an offender showing a "particular disregard for the law," for the purposes of Paragraph 398(c) of the Immigration Rules, that was a different test from Section 72.

The Respondent's Submissions

25) On behalf the respondent, Mr Whitwell referred to the judgment in JZ (Colombia) v SSHD [2008] EWCA Civ 517, where at §10, Tuckey LJ made clear even if there is only a low risk of reoffending, but that risk involves the commission of a very serious offence, it is permissible to conclude that such a person is a danger to the community.

26) It was plainly open to the respondent to have considered the seriousness of the consequences of re-offending even if the risk might be low. The test under the second limb of Section 72 was whether the appellant constituted a danger to the community of the UK, rather than an assessment of whether he would be convicted of a further offence. If the test was one of further conviction, which excluded compulsory detention and treatment under the Mental Health Act (using common terminology, being "sectioned"), Parliament would have said so. Moreover, such a distinction would lead to an impermissible degree of speculation as to the likelihood of prosecution versus mental health treatment. In addition, by analogy, Section 117D(4)(c) of the 2002 Act included, as part of the definition of imprisonment, those who had been detained in hospital.

27) While the appellant sought to explain his offending by reference to his mental illness, the extent to which his mental illness was a contributory factor in the appellant's index offence of rape was unclear. Whilst hospital records in 1997 and 1999 indicated mental health issues, it was also said that the appellant had used drugs, indicative of criminal tendencies, since he was 16. Even if that were incorrect, the explanation of mental health for the appellant's offending did not mean he constituted less of a danger, or that his previous offences were less serious.

28) It was also important to consider the appellant's conduct regardless of prosecutions, as relating to the danger the appellant constituted. His conduct included:

    a) in 2010, he was arrested for threatening and intimidating behaviour against hospital staff and fellow patients;

    b) in 2012, he admitted to carrying a knife and was reported to be doing so on 9th November 2013 by a member of hospital staff;

    c) in February 2013, he presented at hospital heavily intoxicated and displaying threatening and abusive behaviour by punching windows when the police were called;

d) between May and December 2015, he breached his tagging curfew and failed to allow officers access to his property;

e) in July 2015 he was arrested on suspicion of affray;

f) in August 2016 he started drinking and punched a man on a bus and had thoughts of carrying a knife; and

g) in September 2016 he was readmitted under the Mental Health Act after threatening to kill one of his housemates with a knife two days previously.

29) In summary, the appellant's conduct, reflective of the danger he constitutes includes threatening, abusive, and intimidating behaving towards others, as identified in Dr Preston's reports; a history of carrying knives; violence; and threats of violence. The appellant has a documented mental health and criminal offending history going back nearly 30 years. In the period between 1994 and 2000 the appellant was repeatedly hospitalised whilst also being convicted of offences including theft, assault, rape and wounding (stabbing). In the period 2010 to 2021, on release from prison in 2011 he was admitted to hospital after hearing voices and threatening others. In 2014 he was reported as hearing voices telling him to carry a knife and whilst his health condition appeared to be stable in 2014, he breached a tagging order. In 2015 he was arrested for affray and sectioned. In August 2016, while drinking, he assaulted a man on a bus and had thoughts of carrying a knife and was sectioned the following month.

30) It appears, in the context of close monitoring from 2018 to now, that the risk posed by the appellant is currently being managed. However, to isolate this period from the danger constituted by the appellant over the last 30 years is not appropriate. Taking the current lack of offending out of isolation, would mean, as a logical extreme, that as a person had not committed an offence since their last offence, they do not constitute a danger.

31) Moreover, the respondent criticised Dr Preston's reports for failing to consider behaviour which, although not resulting in a conviction, demonstrates that the appellant constitutes a relevant danger. For example, at §7.9, [ASB/33] ASB, in her fourth report, Dr Preston says the following: "To his credit, [AMA] has not received any criminal convictions since 2010. Eleven years being conviction-free suggests [AMA] has developed skills in self-control and emotional management." This assessment plainly ignored the appellant's conduct, as already outlined.

32) Moreover, Dr Preston did not explain why she took the appellant's current assertions of insight and abstinence at value, given the history of his previously unreliable claims to be abstinent from alcohol and drugs. Headnote (2) of JL (medical reports – credibility) China [2013] UKUT 00145 confirmed that we might attach less weight to Dr Preston's reports, where her assessments were dependent on the accuracy of the appellant's assertions.

33) In addition, Dr Preston had applied the wrong test, referring to the risk of offending not being "inevitable" (§7.3, [ASB/32] ASB). The appellant might still constitute a real danger, even if the risk of his further offending was not "inevitable".

34) Dr Preston had also failed to distinguish between the danger which the appellant constitutes, and how that danger might present were it not for the extensive mental health and social support that he currently receives. This was why Restivo was relevant. Moreover, while applying a different statutory test, at §59 of Chege, the Tribunal explained that there might be an explanation for a hiatus in offending, where the criminal was too unwell, but the lack of offending may be of little significance; and §46 of Binbuga identified an error where the judge below had taken out of context the lack of offending for a particular period.

35) In this case, a similar error would be to focus on the appellant's recent stability, due to 24-hour monitoring, supported accommodation, and extensive medical care. Instead, Mr Whitwell urged us to consider the appellant's history in the round. Merely by asserting that the appellant was on a trajectory of self-regulation in the last five years, rather than considering the danger he had consistently constituted over nearly a 30-period, was to take specific periods out of context. Even as recently as 2016, he had threatened to kill a housemate with a knife. Moreover, the appellant was inviting this Tribunal to adopt too high a threshold. There did not need to be a very serious danger of a very serious offence, merely a real risk.

36) Moreover, the appellant was inviting us to speculate that the current package of enhanced would always be provided.

DISCUSSION AND CONCLUSIONS

37) First, we do not accept Mr Chirico's submission that the test of whether the appellant constitutes a danger to the community of the UK (the second limb of Section 72 of the 2002 Act) requires a danger of future prosecution. We see no reason to put any gloss on the words used. The real risk has to be of future danger not future prosecution. If the future danger would lead to detention in hospital, that is no less a danger. We accept the respondent's position for a number of reasons. First, the interpretation which Mr Chirico asks us to adopt defies common sense. For example, where, as in the appellant's case, he has threatened to stab someone with whom he lives, in circumstances where he has suffered auditory hallucinations, has carried knives on an intermittent basis, and has previously stabbed someone, the fact that he is then sectioned rather than prosecuted for the threats to stab someone does not detract from the danger he constitutes.

38) Second, were there such a limitation, we would have expected Section 72 to have said so, and it does not. As we have said, there is no need for a gloss on the statutory words.

39) Third, to require prosecution for there to be a danger flies in the face of the authority of EN (Serbia) that there is does not need to be a causal link between the particularly serious crime (the first limb of Section 72) of which someone has been convicted and the danger which the appellant constitutes. Neither EN (Serbia) nor any other authority to which we have been referred supports the limitation contended for by Mr Chirico.

40) We accept that the fact that someone has been convicted of a particularly serious offence may have a bearing on whether the criminal poses a danger, as Stanley Burton LJ makes clear, but it does not follow that there is no danger without the risk of prosecution, or even that such danger has to be very serious. Indeed, Mr Chirico accepted that there may be instances of someone posing a "low risk", but "high consequence" (the JZ (Colombia) point) which could still constitute a relevant danger.

41) We accept that there are some risks of conduct which do not, without more, amount to the appellant constituting a danger. The unlawful use of drugs, alone, is not a relevant "danger." Where it may become relevant is, as here, if it may lead to a deterioration in the appellant's mental health so that he becomes paranoid and starts hearing voices telling him to stab people. Even if, in a particular instance, the appellant does not act on those voices, but instead, through greater insight, calls those treating him for help, we do not consider that this negates the danger, when looked at in context. Put another way, where the consequences of a danger crystallising are so serious, (to use the paradigm we discussed with Mr Chirico of a mitigated risk that someone might kill others), we struggle to see the circumstances in which someone would not constitute such a danger, even where there are mitigating factors, if the danger is current. This is different for example, from the situation where the conduct causing concern has not occurred for many years and a person is rehabilitated. In that case, recovery would be complete and therefore the danger is not current. We do not rule out the relevance of mitigations if those are sufficiently enduring and effective so as to entirely negate the danger posed. However, when considering all of these factors, we agree with Mr Whitwell's submission that it is important not to take out of context a recent period of lack of offending or relevant conduct. We have to consider the events as a whole.

42) Turning to the appellant's specific circumstances, Dr Preston has identified mitigating factors as including the appellant's increased insight into his behaviour and its impact on others. She points out static factors, which artificially inflate the risk scores generated under standards assessment criteria, such as the absence of employment, which do not reflect the appellant's increased insight and lower risk.

43) However, we return to one of Mr Chirico's submissions in relation to the "trajectory" of risk. He submitted that recovery from mental ill-health may not be a linear path, and there might be outlying incidents on the path of recovery such as the appellant's recent return to drug use, which

prompted the decline in his mental il-health, albeit without any threatening behaviour, because of his greater insight.

44) The central weakness of that submission is that it recognises that the appellant remains on the journey of recovery. His recovery cannot, in any sense, be seen yet as enduring or effective. Even the reduced package of support which the appellant needs to manage his condition includes living in supported accommodation, with staff on site at his current residence between 9am and 5pm, and a member of staff available 24/7 should they be needed, as outside of those hours, they are employed to stay in a property next to the main house on a shift basis (§3.3.12 of Dr Preston's fourth report, at [ASB/17]). Even in that setting, in February 2021, with the smell of cannabis in his room, staff observed personality and antisocial behaviour traits, and the appellant bullying his co-residents and making threats (§3.3.7, [ASB/16]).

45) We do not discount the mitigating impact of medical treatment. We accept that the appellant is likely to be able to continue to access some form of support network. We do not, however, accept that even with the appellant's support network, he does not pose a real risk of harm to others. His condition is managed, provided a delicate equilibrium is maintained. Where there are changes to that support (Covid limiting access to gym and counselling; or a proposed change to accommodation), there is a lengthy history of threats, violence, and other harmful behaviour. When viewed as part of the appellant's consistent pattern of behaviour since 1994, even noting the recent prospects of greater insight and even noting the assessment that the appellant poses a low risk of reoffending, the consequences of the appellant's conduct are, on any view, potentially serious, involving threats of violence and possession and use of knives. We have no hesitation in concluding that the appellant remains a danger to the community to the UK, notwithstanding the high quality of the professional care he currently receives.

46) On the facts established in this appeal, the appellant has not rebutted the presumption under Section 72 of the Nationality, Immigration and Asylum Act 2002 that he is a serious criminal, having been convicted of a particularly serious crime and constituting a danger to the community of the UK. The consequence is that we must dismiss his protection appeal.

Decision

47) We agree that the presumption under Section 72(2) of the 2002 Act applies. The appellant has not rebutted that presumption. Pursuant to Section 72(10), we must dismiss the appellant's appeal on asylum grounds. His claims under the ECHR remain unaffected.

Signed: J Keith

Upper Tribunal Judge Keith

Dated: **7th February 2022**

ANNEX: ERROR OF LAW DECISION

Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: PA/03329/2016

THE IMMIGRATION ACTS

Heard at Field House

On the 29th July 2019 and written submissions provided on the 12 August 2019

Decision & Reasons Promulgated

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Before

UPPER TRIBUNAL JUDGE REEDS

Between
AA
(ANONYMITY DIRECTION MADE)

Appellant

and

(THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Mr B. Bundock, Counsel instructed by TRP Solicitors
For the Respondent: Ms Isherwood, Senior Presenting Officer

DECISION AND REASONS

1. The appellant appeals, with permission against the decision of the First-tier Tribunal (hereinafter referred to as the "FtTJ") promulgated on the 14th January 2019.

2. The FtTJ allowed the appeal of AA on Article 3 of the ECHR against the decision of the Secretary of State to refuse his protection and his human rights claim and in the context of the respondent having made a deportation order against him under Section 32(5) of the UK Borders Act 2007 but during the course of the decision upheld the Section 72 certificate on the basis that he was a danger to the community and thus was excluded from the Refugee Convention.

3. I make a direction regarding anonymity under Rule 14 of the Tribunal Procedure (Upper Tribunal Rules) Rules 2008 as the proceedings relate to the circumstances of the appellant and his on- going protection claim. Unless and until a Tribunal or court directs otherwise the appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him. This direction applies both to the appellant and to the respondent. Failure to comply with this direction could lead to contempt of court proceedings.

The Background:

4. The appellant is a citizen of Somalia. There is a long litigation history to this appeal set out in decisions of the FtT and the Upper Tribunal which I shall summarise.

5. The appellant is a national of Somalia born on 20th January 1966. He entered the United Kingdom on 22nd January 1994 and claimed asylum at Heathrow on the basis that he was Somalian and that claim the Secretary of State refused. After some protracted litigation, his asylum claim was again refused but the appellant was granted Exceptional Leave to Remain on 28 August 1997.

6. On 1 May 1995, shortly after his arrival, the appellant was convicted at Bristol Crown Court of rape and sentenced to 30 months' imprisonment. On 19 March 1999 the appellant committed an offence of assault occasioning actual bodily harm for which he was sentenced on 19 March 1999 to a hospital order at Southwark Crown Court.

7. On 15 March 2000 at Middlesex Guildhall Crown Court the appellant received a further sentence of five years' imprisonment varied to 42 months' imprisonment on appeal, having been convicted of unlawful wounding.

8. The Secretary of State proceeded to issue a notice of liability for deportation which was served on the appellant on 8 February 2008 because of his conviction for rape in 1995 and his conviction for wounding in 2000.

9. In June 2003 the appellant was convicted of failing to supply a specimen and was disqualified from driving and fined. In July 2003 he was convicted of criminal damage and given a 12 months conditional discharge.

10. The appellant appealed a notice of liability for deportation dated 8th February 2008 and a First-tier Tribunal Judge in a decision promulgated on 6 October 2008 (upheld on appeal) rejected the appellant's refugee claim that he would be persecuted as a minority clan member finding in fact that he was a majority clan member – Isaaq. The judge also noted the appellant suffered from mental health problems and HIV but considered that some treatment for HIV and mental illness was available in Somalia. Nonetheless it was found that his family life with his wife/partner a British citizen, (a relationship which is no longer extant), was such that his removal would breach his Article 8 rights even though they did not live together. It was found that the appellant's wife would face insurmountable obstacles in moving to Somalia. The judge also found that the appellant had apparently been rehabilitated and that he had stated that he no longer took illicit substances or drank alcohol excessively.

11. The appellant was then granted discretionary leave on 2 March 2010 until 2 September 2010. On 12 October 2010 the appellant was served with notice of liability for deportation following his conviction on the same date for destroying or damaging property. He was convicted of affray and received a total of twelve months' imprisonment concurrent for both offences. During the course of the twelve months prison sentence imposed on 12 October 2010, the appellant was remanded to a psychiatric hospital but was arrested on the same date for threatening and intimidating behaviour against female nurses. The appellant's licence was revoked, and he was transferred to HMP Ranby on 14 January 2011 to complete his original sentence.

12. The appellant made an application for a further period of discretionary leave on 22 March 2011 but on 4 February 2013 a further notice of liability for deportation was issued whereupon the appellant applied for asylum on 11 December 2013.

13. Finally, on 21 April 2015 a decision to deport the appellant was made.

14. During the period of May to December 2015 the appellant breached his tagging curfew and failed to allow EMS Officers access to the appellant's property and failed to report.

15. In July 2015 the appellant was arrested on suspicion of affray and on 18 September the appellant was sectioned under the Mental Health Act and admitted to St. Anne's Hospital in London until he was discharged on 11 November 2015.

16. On 23 November 2015 a Section 72 of the Nationality, Immigration and Asylum Act 2002 notice was sent to the appellant's representatives and in the same month his Section 4 Support was discontinued as he failed to report to the Home Office and failed to be at his authorised address during curfew times and failed to use the funds available on his 'Azure' card.

17. Finally, on 21 March 2016 the Secretary of State made a decision refusing the appellant's protection and human rights claim.

18. He appealed against the decision of the respondent who, on the 21 March 2016, refused his protection and human rights claim in the context of the respondent having made a deportation order against him under Section 32(5) of the UK Borders Act 2007.

19. The appeal was heard by the FtT (Judge Walters) on the 16th November 2016. In a decision promulgated on the 20th December 2016 the FtT dismissed the appeal on all grounds. The FtTJ found that section 72 of the 2002 Act applied and therefore the appellant could not take the benefit of the Refugee Convention and for the same reason he was excluded from humanitarian protection. The judge found that although the appellant faced what were undeniable hardships and return to Mogadishu, they would not reach the high level necessary for him to succeed under Article 3 of the ECHR. As to his risk of suicide, the judge considered that that could be managed in the UK and on any journey to Somalia and that if his family in the UK was properly notified, it will be possible for them to make private arrangements for him to be met at the airport and be admitted if necessary to the mental health hospital in Mogadishu. The judge concluded that with financial support from his family, the appellant would not be destitute or find himself in a position where he would be in chained and that a supply of medication from the NHS would likely to be provided by the NHS on return.

20. The appellant sought permission to appeal that decision and the grounds of challenge were that the judge took an irrational approach to the Section 72 certification; failed to apply rationally the country guidance case of **MOJ & Others (return to Mogadishu) CG [2014] UKUT 442 (IAC**; failed to have regard to material evidence of the risk to someone with a mental illness of a specific type suffered by the appellant; erred in treating of the Article 3 and Article 8 claims as coterminous failed to consider the appellant's case under Article 15(c) of the Qualification Directive and failed to apply the Ravichandran principle.

21. First-tier Tribunal Judge Ford granted permission on the grounds (ii) to (vi) but refused to grant permission in relation to the judge's approach to the Section 72 certification.

22. The appeal was heard by the Upper Tribunal (Judge Rimington) who, in a decision promulgated on the 8th June 2017 dismissed his appeal.

23. As to the ground relating to the Section 72 certificate, the UTJ set out that permission to appeal on the Section 72 ground was renewed to the Upper Tribunal and apparently refused by Upper Tribunal Judge Freeman. That application was renewed before the UTJ at the oral hearing on behalf of the appellant. The UTJ set out her conclusions at 20-22 and found that it was rationally open to the judge to conclude that the appellant had not rebutted the presumption. As to ground 2, the UTJ also found that there

was no failure to rationally apply the country guidance in **MOJ**. The judge made a finding at paragraph 110 that it is clear in Somali society families are regarded as being primarily responsible for the care of family members who are ill-treatment and it was illogical but not irrational to find that it could be reasonably expected the appellant's family members in the UK would support him. As to ground 3, the UTJ did not accept that the judge failed to assess adequately the mental health evidence including that from Dr Hoehne or failed to have regard to material expert evidence. The UTJ considered that the FtTJ had clearly addressed the issue of the chaining but noted that the appellant at paragraph 109 was in fact a member of the majority clan on return to Mogadishu which would afford him some protection and of the improvement in the conditions in Mogadishu and that not all hospitals adopted such practices. In relation to ground 4, the UTJ did not accept the argument that the judge treated Articles 3 and 8 as being coterminous on the basis that it had been clear that the judge made a separate finding in relation to Article 3 at paragraph 111 and many of the factors and the evidence relevant in this appeal were material to both the Article 3 and the Article 8 considerations. As to ground 5, the UTJ was not persuaded that there was any material failure to consider the appellant's case in relation to Article 15(c)**.** Humanitarian protection had been excluded, owing to the finding that the judge's findings on the Section 72 certificate and he addresses this at [94].

24. In summary, the UTJ reached the conclusion that there was no error of law in the decision stating that he judge clearly considered the grounds of appeal that were open to the appellant, finding that the level of severity necessary for a breach of Article 3 was not reached and nor indeed were there compelling circumstances such that the decision to remove him was disproportionate in view of the public interest. Thus the UTJ upheld the decision of the FtTJ.

25. The appellant sought permission to appeal the decision of the UTJ on the 26th June 2017 and permission on the papers was refused. On renewal, Lord Justice Hickinbottom made reference to the main grounds of appeal which related to Article 3 and the decision of Paposhvili v Belgium [2017] Imm AR 867 and directed the Secretary of State to respond to the Article 3 grounds and whether she accepted, on the evidence before the FtTJ, that the appellant satisfied the test in Paposhvili and then permission would be further considered (decision made on 8 February 2018).

26. On the 15th May the parties reached a consent order which allowed the appeal against the decision of the FtTJ and remitted the appeal to the FtT for a rehearing. The consent order was accompanied by a statement of reasons. The relevant paragraphs are as follows:

> "7. The FTT needed to determine whether AA faced a real risk of being chained in Somalia, as a result of his mental health, and if so, whether that would mean that deportation would be in breach of article 3.

> 8. The SSH accepts (contrary to what the UT held) that the FTT did not make any, or any adequate findings on whether there was a real risk of AA being chained by reason of his mental illness. The FTT found that AA "need not" chained but that is not the same as finding that there was no real risk of his being so chained. The FTT therefore appears to have misdirected itself as to the test to apply.
>
> 9. In the alternative the FTT has failed to give adequate reasons for its conclusions. Even if the hospital in Mogadishu did not use chains and even if AA would receive money from relatives in the UK, the FTT has not explained why it felt able to conclude that there was no real risk that AA might be detained in one of the other centres that did use chains.
>
> 10. That provides a sufficient basis for this appeal to be allowed without the need to consider AA's other grounds of appeal. Accordingly the SSHD agrees to this appeal being remitted for a full reconsideration in the first-tier Tribunal.

27. The appeal then came before the FtTJ on the 29th November 2018.

The Decision of the First-tier Tribunal

28. In a decision promulgated on the 14th January 2019 the FtTJ dismissed his appeal on refugee and humanitarian protection grounds allowed the appeal on Article 3 grounds.

29. In the light of the evidence provided on behalf of the appellant and the evidence provided on behalf of the respondent, the FtTJ set out at paragraph 40 that it appeared to be common ground that the appellant would face a real risk of being kept in chains. At paragraphs 72 – 81 the FtTJ again set out the position of the respondent who did not dispute that there was a real risk of the appellant being subject to Article 3 mistreatment and set out the evidence upon which that issue had been agreed.

30. It had been argued before the FtTJ that as there was a section 72 certificate, this continue to apply to exclude the appellant from succeeding in his protection claim either under the Refugee Convention or on the grounds that he qualifies for humanitarian protection under paragraph 339C of the rules. At paragraph [44] the FtTJ sets out that he queried whether there was in fact an extant refugee claim but that it was submitted on behalf of counsel that there was such claim on the basis that the appellant was a member of a particular social group, namely persons who are mentally ill.

31. It was accepted that the appellant had been convicted of a particularly serious crime, but it was submitted that the appellant had rebutted the presumption that he presented a continuing danger to the community. On that issue the FtTJ summarised the medical reports at paragraphs 51 – 66 and at paragraph 67 – 69 also summarised the psychological report of Dr P and the risk assessment. At paragraph 54, the FTT J considered whether the appellant's mental illness was a mitigating factor in the commission of

serious crimes but concluded that it had been unclear to what extent his mental illness had been a contributory factor in the commission by him of the particularly serious crimes of rape and wounding with intent but even assuming that it was, the judge did not consider that it was as significant mitigating factor on the basis of the evidence that out by Dr K pointed to the root cause of the mental illness being the appellants abuse of drugs. The judge considered the most recent risk assessment by a psychologist at paragraph 67 — 69 who had reached the conclusion that he presented a low risk of violent offending based on the assumption that he continued to live in supported living accommodation that he continued to take the medication prescribed and that he was absent from drugs and alcohol. This was a recent change which needed to be maintained. The judge recorded at [69] that the risk assessment at paragraph 7.05 stated that the assessment of risk using the level of service case management inventory indicated "high level of risk of general offending" at the current time and that the doctor had downgraded this risk of non-violent reoffending from high to moderate because his lack of engagement in employment which was a factor which elevated the overall risk from moderate to high. The FTT J considered that since gaining employment had been identified by the doctor as one of the factors which was likely to reduce his risk of reoffending over time, he did not consider that this justified taking the lack of engagement in employment out of the risk assessment in order to reduce the assessment of the level of risk from high to moderate.

32. At paragraph [70], the FTT J concluded that the appellant continued to present a high level of risk of general reoffending and that also there was a significant risk of violent reoffending if the appellant did not, for example, remain absent from drugs or alcohol misuse. The judge took into account that he had no convictions the past eight years that this was because his criminal offending since 2010 (set out in the report of Dr K, Dr L, Dr A), had been dealt with as a symptom of his mental illness and that it had not been in the public interest to prosecute him. The judge found that the appellant had not rebutted the presumption that he continued to present a danger to the community. Therefore, by virtue of operation of section 72 he was excluded from protection under the Refugee Convention and from humanitarian protection.

33. As a consequence of that conclusion, the judge did not set out any further analysis of the basis upon which Counsel had submitted he formed part of a particular social group namely persons were mentally ill, as the Refugee Convention ground relied upon.

The Appeal before the Upper Tribunal:

34. The appellant sought permission to appeal that decision and permission was refused by FtTJ Grimmett on the 8th May 2019 but following a renewal application, was granted on the 25th June 2019 by Upper Tribunal Judge O'Callaghan for the following reasons: -

> "I remind myself that "arguable," is a low hurdle to cross. It is arguable that the FtTJ erred in its approach to the medical evidence before it when concluding that the root cause of the appellant's illness was self-induced and so was not a significant mitigating factor [54] and that such arguable error adversely flowed into subsequent considerations of dangerousness under section 72 of the Nationality, Immigration and Asylum Act 2002.
>
> Permission to appeal is granted on all grounds."

35. The appellant was represented before the Upper Tribunal by Mr Bundock, of Counsel. The Secretary of State was represented by Ms Isherwood, Senior Presenting Officer.

36. Neither advocate had provided a skeleton argument in support of their respective positions. I therefore heard submissions from both parties which are set out in the Record of Proceedings.

37. There was one issue that the parties had not addressed which related to whether to FTTJ Monson's had jurisdiction to consider and determine the Appellant's claim under the Refugee Convention. In a joint agreed minute filed by the advocates on the 12th August 2019, the parties agreed that the decision of the Court of Appeal had remitted all matters to the First-tier Tribunal.

The submissions made on behalf of the appellant:

38. Mr Bundock relied upon the written grounds and supplemented them with the following oral submissions.

39. In relation to ground 1 it was asserted that The FTT materially erred in failing to treat the links between A's offending and his mental health as a mitigating factor and/or gave no or inadequate reasons for concluding that they were not. It had been submitted before the FtTJ that the close link between A's offending and his mental health was "*strong mitigation*" in the context whether "*a danger is sufficiently serious to justify an exclusion from protection from refoulement*" (para. 24 of Skeleton Argument before FTT).

40. However The FTT held at paragraphs 54 and 70 that the appellant's mental illness had been a "*contributory factor in the commission by him of the particularly serious crimes of rape [in 1995] and wounding with intent [in 2000]*", it was "*not [...] a significant mitigating factor as the evidence canvassed by Dr points to the root cause of the mental illness being the Appellant's abuse of drugs*"

41. As for the conduct since 2010, the FtTJ stated at [70] that "*[w]hile the Appellant has no convictions for the past 8 years, this is because his criminal offending since 2010 (as detailed by Dr K, Dr L and Dr A) has been dealt with as a symptom of his mental illness, and it has not been in the public interest to prosecute him*" and that in those circumstances,

"*the Appellant has not rebutted the presumption that he continues to present a danger to the community*" (see [70]).

42. The FtTJ rejected the submission that the appellant's mental illness was a mitigating factor in assessing the seriousness of any past or potential offending on the grounds that it was essentially self- induced. This is set out at paragraph [54] of the decision. The judge accepted that this could be relevant but did not find that his mental illness was a mitigating factor because he had caused his mental illness by his abuse of drugs and alcohol. The FtTJ had found that the root cause of his mental illness was the appellants abuse of drugs.

43. In reaching this conclusion the judge was in error. Dr K's evidence did not support the conclusion that the "root cause" of the appellant's mental illness was drug abuse and it is perverse to conclude otherwise (see paragraph 12.1 opinion and recommendations).

44. Mr Bundock submitted that knowledge the expert evidence said that the root cause of his mental illness was the abuse of drugs. Therefore it was not open to the judge to find that this was the root cause of the appellant's mental illness. Furthermore, it was not rational to identify a single root cause of a person's mental illness when on any view the evidence demonstrated that there was a complex situation and a range of factors.

45. The judge therefore misdirected himself when looking at the evidence. At paragraph 51 the FtTJ made reference to the decision of a previous judge (FtTJ Walters) and cited Dr K's report. However the question is whether the FtTJ was directing himself to the original report of Dr K or whether in fact he was simply taking the conclusions from the determination of judge Walters. This is exemplified by the contents of paragraph 52 where the judge did not set out the entire paragraph of the appellant's background information and therefore was not wholly consistent with Dr K's report. At paragraph [53] the judge made reference to the period between 2012 – 2013 and at [54] concluded that the appellants mental illness was not a significant mitigating factor as the evidence set out by Dr K's points to the root cause of the mental illness being the appellant's abuse of drugs. The report set out the background information and there was no significant history of alcohol abuse outlined in 1993 (see page 3 of the report). The next entry related to 1997 which stated that he was exhibiting paranoid ideation and isolating himself. At that time he was reported to use Khat and whilst it is stated that a visiting psychiatrist expressed the view that the appellant's condition was caused by the abuse of Khat such a diagnosis should be treated cautiously as it is not known the quality of the assessment of that psychiatrist. The evidence of Dr L (page 95) summarised his background and stating that his condition was exacerbated by drug use. He therefore submitted that there was no clear diagnosis in 1997 that his mental illness was caused by drug abuse but that his diagnosis of psychosis was exacerbated by drug use.

46. Therefore, the FT TJ at paragraphs 52 – 54 misdirected himself by finding that the appellants mental illness was as a result of drug abuse. The judge misinterpreted the medical evidence as the medical evidence demonstrated that the appellant had been diagnosed as a paranoid schizophrenic from the outset with some role for drug abuse. It is against this background that it could reasonably be said that the FtTJ had gone straight to the decision of Judge Walters rather than considering the original report of Dr K.

47. Mr Bundock further submitted that there was significant evidence before the judge linking the appellant's mental illness causatively with his childhood experiences of serious trauma. There was evidence to the effect that the appellant's "dysfunctional personality traits are likely linked to his early traumatic experiences and disruption" as set out in the evidence of Dr A (the treating physician) at page 93..If the judge was to reject this evidence, he was required to give reasons. The judge failed to give reasons for this. In the alternative, the judge failed to take this into account when reaching a conclusion as to what the root cause of his mental illness was.

48. Similarly, there was professional evidence in the medical reports (Dr A) setting out that the appellant's own drug abuse should be seen in the context of self-medication for a pre-existent mental illness. Insofar as the appellants non-compliance of medication and dependency on alcohol and other drugs increased the risk of offending conduct, the FtTJ was required to have regard to the evidence that "maladaptive coping strategies, such as self harming behaviour and use of drugs and alcohol postcode was evidence of his mental illness and his dependency on drugs was evidence of his vulnerability and therefore a mitigating factor rather than an aggravating factor.

49. Mr Bundock submitted that the evidence of Dr A was at the appellants abuse of alcohol was a coping strategy and that this had been linked to earlier trauma.

50. Even if this was the root cause, the FT TJ failed to ask himself what was the cause of the alcohol and drug taking? In circumstances where Dr A had stated that there were maladaptive coping strategies based on his early trauma.

51. He submitted that the second piece of crucial evidence was set out in Dr K's report at K15. This set out the family history and that his father and brother suffered from mental illness and that it stated that "reports available to me that his brother committed suicide". It was also stated that the appellant reported in an interview that his mother suffered from mental illness and left the family when young. The FtTJ was required to take into account the family history of severe mental illness and there was no indication that he did so. This undermines his conclusion at [54].

52. In relation to Ground 1 (b) he submitted that the FtTJ irrationally relied on the fact that it not been in the public interest to prosecute the appellant since 2010 is a factor weighing against, rather than in favour, of his claim.

53. It is submitted that the fact that his conduct since 2010 has been treated domestically as (i) a symptom of his mental illness; and (ii) as such not appropriate to be dealt with by the penal system, is at the very least a strong indicator that it should not be treated as a ground for exclusion from the protection of the Refugee Convention on the grounds of criminality. If that is so, then the appellant's adverse conduct since 2010 stood to be disregarded and the FtTJ erred in this.

54. Mr Bundock submitted that the last conviction was in 2010 and it been submitted before the FtTJ that this was a factor weighing in his favour. However, the FT TJ concluded that he was still behaving in a criminal way but that he had not been prosecuted for it because it would not be in the public interest to do so. The FtTJ erred in treating this as a negative factor weighing against the appellant. This failed to properly take into account and give the weight that it rationally deserved.

55. In relation to ground 2 it is submitted that the FtTJ erred by his failure to identify and apply the material distinction between more and less serious crime. By reference to the decision of EN(Serbia) it is clear that prospective criminality must reach a certain level of seriousness before a person should be treated as constituting a danger to the community. In the present case, the FTT had before it evidence of a *low* risk of violent reoffending and a *moderate* risk of non-violent reoffending.

56. As to ground 3, Mr Bundock relied upon the written grounds. Ground three asserted that there had been a failure to determine the question of 'dangerousness' on the basis of the situation at the present time. He submitted that the judge had accepted the expert evidence of Dr P concerning the appellant's current circumstances and that, provided there is no change of circumstance, A's mental health is presently well-managed, and he poses a significantly reduced risk of offending. Therefore the judges required to assess the situation as matters stood at the time of the hearing.

57. However the FT TJ gave no explanation for the kind of circumstances or factors that might be relevant to the appellant circumstances changing nor does he identify any evidence or provide an explanation or reasoning. This was a crucial error.

58. The FtTJ went behind the present assessment of risk, based upon A's stable circumstances.

The submissions made on behalf of the respondent:

59. There was no rule 24 reply issued on behalf of the Secretary of State. Ms Isherwood therefore made oral submissions which can be summarised as follows.

60. She submitted that there was no error of approach in the decision of the FtTJ and that the grounds essentially sought to reargue the points that had been advanced before the FTT. She submitted that the weight to be attached to the medical reports was a matter for the judge.

61. In answer to the submission made that the judge failed to accurately summarise the medical evidence, she submitted that the judge properly set out the salient parts of the medical evidence and directly considered the submissions made on behalf of the appellant as set out at paragraphs 47 – 50 of the decision. It was open to the judge to reach the conclusion at paragraph 54 that the root cause of his mental illness was related to his abuse of drugs. She referred the Tribunal to the decision of Judge Buchanan at [C4 paragraph 18] which made reference to him continuing to suffer from depression and paranoia and "was drinking to excess and taking drugs". Furthermore at paragraph 19 the events of the year 2000 were described as follows "in 2000 the appellant entered into an argument with a Somali drinking companion. They also both took drugs. During the argument the appellant stabbed this other man and he was arrested and initially sentenced to 5 years in prison, reduced on appeal to 42 months." At paragraph 25 [C5] Judge Buchanan recorded that the appellant had stated he had given up drugs and stop drinking but that at paragraph 52, the judge made reference to the appellant having committed further offences after his release from prison including driving whilst disqualified, failing to give a specimen causing criminal damage. At paragraph 55, the judge considered the appellant's claim that he had not taken drugs or alcohol since 2005 and was living an exemplary life and following a more conformist adherence to his religion. At paragraph 55 the judge took into account evidence from 2008 testifying to his help in the community and therefore paragraph 56 the judge referred to there being evidence to suggest that he was a "reformed person".

62. In the evidence of Dr K, his previous psychiatric history was set out and that in February 1998 when he visited a housing office he smashed 15 windows at the hostel. When on leave, he became violent in the streets and smashed a telephone box and was taken into police custody. It was stated that "a diagnosis of Khat abuse and possibly PTSD was made". He was referred to a hostel for alcohol and anger difficulties but was later evicted (see K9). At K11 of the same report another psychiatrist reported in 2011 that he had been discharged from the community team because it was not possible to effectively manage his condition and the community or mitigate existing risks to him or others. At K 13 on 16 February 2013 it was recorded that he presented at an emergency reception centre and was heavily intoxicated with alcohol and displayed threatening and abusive behaviour. He was assessed and it was reported that he'd been arrested in the week for common assault and that he had more outstanding offences committed in the past. At K 14 the appellant's drug and alcohol history

was set out and that he started drinking alcohol the age of 16 and was reported to have started to drink excessively since he moved to the UK and that he reported using Khat since the age of 16.

63. Ms Isherwood therefore submitted that the abuse of alcohol and drugs of been raised as an issue throughout his psychiatric history.

64. At K 15 on 18 October 2013 the appellant denied drinking alcohol or using drugs._She stated that whilst Counsel for the appellant had submitted that little reliance could be placed on parts of the medical reports, the same could be said as to the appellant’s evidence as to his early life. She submitted that there was no reference in the medical reports by way of independent evidence to demonstrate that his family members had any form of mental illness. It was plain from the report at K 15 that it had been recorded by Dr K that on 18 October 2013 the appellant reported in contrast to his previous accounts that he had been well looked after as a child and denied incidence of being hit or abused. Therefore his account of personal history had been inconsistent.

65. He was reported to act in a threatening, aggressive manner when under the influence of alcohol. The last incident under the influence of alcohol is reported for the 16 February 2013 but the risk of disengagement from services continued to be high. It was recorded at paragraph 6 (K 19) that the appellant seemed inconsistent in his engagement with mental health services;. A good engagement followed by detached or evasive interactions with services. There is evidence that is compliance with all medication is intermittent. The final opinion at paragraph 12 (K 20) and that in the doctor’s view absence of alcohol and illicit substances was essential for him to be managed safely in the community. Therefore she submitted, there was nothing that was incorrect in the summary made by the FT TJ is asserted on behalf of the appellant.

66. As to the report of Dr L (page 95), at page 96 there was reference to the appellant having failed to comply with his medication and having started drinking alcohol again. This was set out at pages 96 – 98 which makes reference to the appellant being relatively stable but then failing to comply with medication and drinking again. She submitted that when the FtTJ considered this at [58] there was nothing incorrect in his summary.

67. Contrary to the submissions made, she submitted that the judge also proper summarised report of Dr P at paragraph 67 – 69. The judge approaches the evidence of Dr P cautiously at [69] in the light of his long history outlined in the earlier reports. She therefore submitted that there was no error.

68. As to ground 1B, the judge’s conclusion at [70] was open to him to make. Whilst the appellant had no convictions, the FtTJ was entitled to give consideration to the other conduct that had been outlined in the reports and the inference that it would not be in the public interest to prosecute the appellant. Therefore the conclusion reached by the FtTJ that he had

not rebutted the presumption and he continued to present a danger to the community was a conclusion that was open to the judge to make.

The reply:

69. Mr Bundock by way of reply, submitted that there was no dispute that alcohol or drugs were relevant to his mental illness but that the FtTJ identified those issues as a root cause or more importantly as a single root cause therefore implying that it was the appellant’s own fault. The question was whether the judge was entitled to find that his conduct was attributable to the appellant. If not, as Dr A stated, the drugs and alcohol abuse was a way of self-medicating and therefore was a properly mitigating factor. He submitted that the judge had to grapple with the evidence is reaching the conclusion that drugs and alcohol with the root cause of his mental illness. The judge did not reject his past history as unreliable.

70. Further submitted that non-compliance is often present with those diagnosed with schizophrenia.

71. As to the medical reports, there had been no dispute that the assessments were contingent on the level of support and living in supported accommodation. However, the issue of the section 72 certificate at be considered in the light of the report of Dr P. He submitted that there was a lack of reasoning in the decision made by the FtTJ. He invited the Tribunal to set aside the decision.

The relevant legal framework:

72. The decision involves a consideration of Article 33(2) of the Refugee Convention and Section 72 of the NIAA 2002; the relevant provisions of which are as follows:

(1) Article 33(2) of the Refugee Convention

"2. The benefit of the present provision may not, however, be claimed by a refugee whom there are reasonable grounds for regarding as being a danger to the security of the country in which he is, or who, having been convicted of a final judgment of a particularly serious crime, constitutes a danger to the community of that country."

(2) Section 72

"**72 Serious criminal**

(1) This section applies for the purpose of the construction and application of Article 33(2) of the Refugee Convention (exclusion from protection).

(2) A person shall be presumed to have been convicted by a final judgment of a particularly serious crime and to constitute a danger to the community of the United Kingdom if he is—

(a) convicted in the United Kingdom of an offence, and

(b) sentenced to a period of imprisonment of at least two years.

…

(6) A presumption under subsection (2) … that a person constitutes a danger to the community is rebuttable by that person.

…

(9) Subsection (10) applies where—

(a) a person appeals under section 82 … of this Act … wholly or partly on the ground that to remove him from or to require him to leave the United Kingdom would breach the United Kingdom's obligations under the Refugee Convention, and

(b) the Secretary of State issues a certificate that presumptions under subsection (2) … apply to the person (subject to rebuttal).

(10) The adjudicator, Tribunal or Commission hearing the appeal—

(a) must begin substantive deliberation on the appeal by considering the certificate, and

(b) if in agreement that presumptions under subsection (2), (3) or (4) apply (having given the appellant an opportunity for rebuttal) must dismiss the appeal in so far as it relies on the ground specified in subsection (9)(a).

(11) For the purposes of this section—

(a) "the Refugee Convention" means the Convention relating to the Status of Refugees done at Geneva on 28th July 1951 and its Protocol, and

(b) a reference to a person who is sentenced to a period of imprisonment of at least two years—

(i) does not include a reference to a person who receives a suspended sentence (unless at least two years of the sentence are not suspended),

(ii) includes a reference to a person who is sentenced to detention, or ordered or directed to be detained, in an institution other than a prison (including, in particular, a hospital or an institution for young offenders), and

(iii) includes a reference to a person who is sentenced to imprisonment or detention, or ordered or directed to be detained, for an indeterminate period (provided that it may last for two years)."

73. Where the Secretary of State has certified his decision under section 72 of the 2002 Act, section 72(1) tells the Court or Tribunal how Article 33(2) of the Refugee Convention is to be applied. Section 72(10) of the 2002 Act requires the Tribunal to begin its consideration of the appeal with consideration of the section 72 certificate. The claimant will have appealed under section 82, 83, 83A or 101 of the Nationality, Immigration and

Asylum Act 2002 (as amended), wholly or partly on the ground that to remove him from, or to require him to leave the United Kingdom, would breach the United Kingdom's Refugee Convention obligations (see section 72(9)(a)).

74. A section 72 certificate has the effect of raising a dual statutory presumption: first, that the claimant has been convicted on a final judgment of a 'particularly serious crime' and second, that he 'constitutes a danger to the community'. In the case of a person convicted in the United Kingdom, section 72(2) provides that both presumptions come into effect where the individual is sentenced to a period of imprisonment of at least 2 years.

75. Both presumptions may be rebutted by appropriate evidence, as set out in section 72(6) and *EN (Serbia) v Secretary of State for the Home Department & Anor* [2009] EWCA Civ 630.

76. If both presumptions are not rebutted, then section 72(10)(b) of the Act requires the Tribunal to dismiss the appeal in so far as it relies on the Refugee Convention ground. No presumptions are raised in relation to human rights.

77. In the decision of EN (Serbia) (as cited) the following was stated at [45]-[47] and at [66]:”

> “45. These remarks apply with equal force here. Moreover, I see no need for any gloss on the express words of Article 33(2). The words "particularly serious crime" are clear, and themselves restrict drastically the offences to which the Article applies. So far as "danger to the community" is concerned, the danger must be real, but if a person is convicted of a particularly serious crime, and there is a real risk of its repetition, he is likely to constitute a danger to the community.
>
> 46. The Appellants submitted that Article 33(2) requires that the danger to the community must be causally connected to the particularly serious crime of which the person has been convicted. I would accept that normally the danger is demonstrated by proof of the particularly serious offence and the risk of its recurrence, or of the recurrence of a similar offence. I would also accept that the wording of Article 33(2) reflects that expectation. But it does not expressly require a causal connection, and I do not think that one is to be implied. By way of example, I do not see why a person who has been convicted of a particularly serious offence of violence and who the State can establish is a significant drug dealer should not be liable to refouled under Article 33(2). In any event, it seems to me that a disregard for the law, demonstrated by the conviction, would be sufficient to establish a causal connection between the conviction and the danger. If so, the suggested added requirement of a causal connection has little if any practical consequence.
>
> 47. I would add that I have no doubt that particularly serious crimes are not restricted to offences against the person. Frauds, thefts

> and offences against property, for example, are capable of being particularly serious crimes, as may drug offences, particularly those involving class A drugs. In addition, matters such as frequent repetition or a sophisticated system or the participation of a number of offenders may aggravate the seriousness of an offence.
>
> ...
>
> 66. I see no reason why a rebuttable presumption, imposed for the purposes of a decision as to whether removal would be in breach of Article 33(1), should be incompatible with Article 33(2) of the Convention, at least in cases in which it may reasonably be inferred that a conviction gives rise to a reasonable likelihood that a person's conviction is of a particularly serious crime and that he constitutes a danger to the community. The Convention does not prescribe the procedure by which the conditions required by Article 33(2) are to be established; and the creation of a rebuttable presumption is a matter of procedure rather than of substance. I accept that the Convention places an onus on the State of refuge. Under section 72, it is for the Secretary of State to establish that the person in question has been convicted of a relevant offence. In practice, once the State has established that a person has been convicted of what is on the face of it a particularly serious crime, it will be for him to show either that it was not in fact particularly serious, because of mitigating factors associated with its commission, or that because there is no danger of its repetition he does not constitute a danger to the community."

Discussion:

78. I remind myself that I can only interfere with the decision of a judge if it has been demonstrated that there was an error of law in reaching that decision.

79. It was accepted before the FtTJ that AA had been convicted of a " particularly serious crime" (at paragraphs 45 and 47) and in the grounds at paragraph 6 because the appellant had been convicted of wounding with intent in March 2000 and sentenced to 3 ½ years' imprisonment. It was however stated in the grounds that " no such concession was made about any offences post-dating March 2000 and in particular no such concession was made about the appellant's conduct since his conviction for affray in 2010 (see paragraph 7).

80. Ms Isherwood raised as a preliminary point that contrary to the grounds, there had been a concession made to that effect. However, the skeleton argument provided before the FtTJ set out at paragraph 21 that the convictions set out by the respondent were admitted but went on to state "It is not in dispute that the appellant had been convicted of a " particularly serious crime" ". The reference made at that paragraph is to a singular crime; that is the conviction for wounding. As set out in EN (Serbia) at [66], in practice once the State has established that a person

has been convicted of what is on the face of it a particularly serious crime, "it will be for him to show either that it was not in fact particularly serious, because of mitigating factors associated with its commission, or that because there is no danger of its repetition he does not constitute a danger to the community." In this appeal the latter was the issue to be determined.

81. The first issue relied upon is that the risk of offending is clearly linked to the appellant's mental health and that this was a " mitigating factor" which the FtTJ failed to take into account.

82. The FtTJ considered this at paragraph 54 :

> "it is unclear to what extent the appellants mental illness has been a contributory factor in the commission by him of the particularly serious crimes of rape and wounding with intent. But even assuming that it was, I do not consider that it is a significant mitigating factor as the evidence canvassed by Dr K points to the root cause of the mental illness being the appellant's abuse of drugs."

83. Mr Bundock submits that the FtTJ rejected the submission that his mental health was a mitigating factor in assessing the seriousness of his past and future offending on the grounds that it was self-induced.

84. I can find no error in the FtTJ's assessment at [54] that it was unclear to what extent the appellant's mental illness had been a contributory factor in the commission by him of the serious crimes of rape and violence. There are no sentencing remarks available in relation to the offence committed in 1995 and the only description of the offence is that self-reported and set out in the report of Dr P at 3.2.6. Similarly there are no sentencing remarks for the offences in 2000. However it seems to me that it can be inferred from the hospital order imposed in 1999 and his previous hospital admissions between 1997 and 1999 that the appellant was suffering from mental health issues for a significant period which may have impacted on his criminality.

85. A careful reading of the medical reports demonstrates that the appellant has been a user of khat since he was 16 years of age and according to his own self report in 1998 was using 3 to 4 bundles of khat for a period of several months (see Dr K: paragraph 4). There are numerous references to abuse of drugs (not just khat) and his excessive alcohol consumption and a first diagnosis was recorded in 1997 in which it was stated that his condition was caused by an abuse of khat.

86. However the diagnosis, which is now agreed upon by the medical professionals is that he suffers from paranoid schizophrenia, dissocial personality disorder and traits of emotionally unstable personality disorder. In my judgement his mental health condition cannot be attributed to one "root cause "as found by the FtTJ. The reports make reference to a number of factors within his history apart from alcohol and substance misuse including a family background of mental health issues and the traumatic

experiences he claimed in Somalia. Against the background of the medical evidence when viewed holistically, it is not possible in my judgment to state that the root cause of his mental illness is his abuse of drugs as the FtTJ did at paragraph [54].

87. However that assessment did not factor into the FtTJ's assessment of whether he was a "danger to the community". At paragraph [70] the FTT J made reference to the risk of further offending in the context of his failure to remain abstinent from drugs and alcohol misuse, which in my judgment was part of the assessment that he was required to consider and part of the objective assessment based on the recognised risk factors identified in the report of Dr K, Dr A and also Dr P.

88. In my judgment, the FtTJ was right to reject the submission that where a person who commits an offence who has a mental health condition is sufficient mitigation to reduce the seriousness of the offence to the extent for that reason alone it can no longer be considered a serious offence. There can be no dispute that someone's mental health condition is a mitigating factor, but it does not mitigate from a more serious offence to a lesser offence. Mental health problems do not reduce the appellant's culpability sufficient for the offence to be considered as one that was not serious.

89. Consequently I find no material error in the FtTJ's approach notwithstanding his reference to the root cause of the appellants mental illness, which is in error.

90. As to ground 1 (b), in assessing whether the appellant is a danger to the community, in my judgment it is necessary to look at the whole of the appellant's conduct regardless of whether he was prosecuted for offences relating to that conduct. There may be many reasons why he was not prosecuted but the conduct and what the appellant did seems to be accepted and is not challenged.

91. That conduct is addressed in the medical evidence post his conviction in 2010. There are a number of examples given in the medical reports from October 2010 until September 2016.

    - In October 2010 he had been arrested for threatening and intimidating behaviour against female nurses.
    - It is further recorded that he was behaving in a threatening manner towards staff and other patients in 2010.
    - In 2012 he admitted to intermittently carrying a knife and is reported to be doing so on 9 November 2013 by a member of the treatment team.
    - In February 2013 the history records that he presented at hospital heavily intoxicated with alcohol and displaying threatening and abusive behaviour by punching windows where the police was called.

- Between May to December 2015 he breached his tagging curfew and failed to allow officers access to his property and failed to report.
- In July 2015 he was arrested on suspicion of affray;
- In August 2016 he started drinking and punched a man on the bus and had thoughts of carrying a knife.
- In September 2016 he was readmitted under the Mental Health Act after threatening to kill one of his housemates with a knife to days before.

92. Consequently as the issue in dispute before the FtTJ was whether AA presently represented a “danger to the community” and therefore rebutted the presumption, the appellant’s general conduct which included his criminality, behaviour and conduct after the offence in 2000 was arguably relevant in deciding that issue. In my judgement the FTT J did not err in law by taking into account other behaviour and conduct since his last conviction in 2000 or 2010.

93. As to ground 2, it is submitted that the judge failed to identify and apply the distinction between more or less serious crime and that the perspective criminality must reach a level of seriousness for being properly treated as a danger to the community. In this context Mr Bundock submitted that the evidence of Dr P had set out a low risk of violent reoffending and a moderate risk of non-violent offending and that the FtTJ failed to analyse what type of offending may have followed from the general risk.

94. At paragraph 67 – 69 the FTT J made reference to the report of Dr P, who was not the treating clinician, but who would been asked to assess the appellant for the purposes of the proceedings.

95. Dr P was asked to prepare a report addressing AA’s risk of reoffending, risk of harm and the extent to which the mismanagement of his mental health informs the risk of reoffending and risk of harm.

96. Having reviewed the evidence, her opinion was that AA presented with a “low-level risk for future violent reoffending at the time of assessment” and “a moderate level of risk for future general (nonviolent) reoffending. Maintaining current stability mental health, maintaining abstinence from alcohol and drugs and gaining employment would likely reduce this risk over time (7.0.3)

97. A structured assessment indicated **a high level of risk for general offending** at the current time. . Dr P’s analysis is at paragraphs 4.2 and 4.3. AA scored 22 (high risk range is 20-29) . At paragraph 4.2 the relevant risk factors identified using the relevant tool included his criminal history, is education history, his lack of employment and previous use of alcohol and cannabis. No evidence to support the presence of pro-criminal

orientation but there was an antisocial pattern including past diagnosis of dis-social personality disorder and pattern of generalised trouble is evidenced by lack of stable employment, financial concerns, lack of higher education, non-rewarding parental relationship later loss of his father and limited engagement in structured leisure activities or meaningful occupation.

98. However Dr P stated that it is important to highlight that AA's risk on this assessment is inflated by his lack of engagement in employment with four automatically assigned points for being out of employment at the time of the assessment; the majority of items that he scores on are static and historical." In my opinion, based on the current assessment of AA, **his risk of general nonviolent offending is moderate rather than high** (7.05) ". Dr P stated it would not be protective for AA to be engaged in employment at the current time as the focus should be on the stabilisation of his mental health. Therefore whilst the lack of employment inflates his risk on the assessment tool, it does not take into account's particular circumstances. Removing those four points would reduce risk to the moderate range and clinical assessment suggested that this was a more accurate appraisal of the current risk, with the most likely offences being offences of theft (see paragraph 4.3).

99. Relevant risk factors identified include AAs problems with alcohol and cannabis use, bearing in mind that is reported abstinence **is a recent change** and this needs to be maintained.

100. Having reviewed the evidence, her opinion was that AA presented with a "low-level risk for future violent reoffending at the time of assessment" and "a moderate level of risk for future general (nonviolent) reoffending. Maintaining current stability mental health, maintaining abstinence from alcohol and drugs and gaining employment would likely reduce this risk over time (7.0.3)

101. Dr P's assessment of risk of violence was undertaken using HCR - 20 as set out at paragraph 5.0. HCR – 20 is a structured assessment of the risk of violence and the tool represents an attempt to integrate evidence-based knowledge of risk factors for future violent behaviour with clinical judgement. HCR – 20 consists of 20 items and that is administered through a process of reviewing an individual's case notes, an interview and psychological testing. Of the 20 items, 10 are termed "historical" making up the more static factors. Another five constitute the "clinical" items which are more dynamic in their nature and are associated with the possibility of change. The last five are called "risk" items and are made with respect to the assessment of the plans that are in place to address the level of risk posed by the individual being assessed.

102. Dr P sets out at table 1 a summary of the historical risk factors; they can be summarised as follows; past use of violence (convictions for rape, wounding with intent and affray as well as a reported history of carrying knives and weapons and exhibiting threatening behaviour and thoughts to

harm others when mentally unwell. His engagement in antisocial and nonviolent offending behaviours as represented by convictions for causing damage to property, breach the peace, theft and criminal damage. His history of problematical relationships with the self-reported use of prostitutes and the use of cannabis but no violence within intimate relationships or significant conflict with peers. His past history of using substances including khat and cannabis as well as alcohol with concomitant deterioration is mental state and past diagnosis of drug induced psychosis and convictions are being drunk and disorderly. As to employment, there is no reported problem but no clear record of any formal employment. There is a clear pattern of breaches of community supervision with convictions of failing to surrender to custody, failing to appear in court and failure to report and attend appointments. There is a reported history of trauma to experience is in Somalia. There are no entrenched violent attitudes, but they can be inferred from his past behaviour and their beliefs supportive of the use of weapons that are been present in the past. There is a clear history of mental disorder with a diagnosis of paranoid schizophrenia as well as evidence of personality disorder with a diagnosis of antisocial (order social) personality disorder.

103. A structured assessment of risk of violence indicates a **low risk of future violent reoffending**; this is whilst he is in supported living accommodation, is taking medication as prescribed and is absent from drugs and alcohol. Should he not have access to support. taking medication as prescribed or relapse into substance to use**, risk of violent offending would rapidly increase to high**. Violence is most likely to occur in the context of deteriorating mental health, precipitated by the prolonged or excessive use of substances and non-compliance of medication (7.0.4)

104. The FtTJ did not accept that the assessment of risk from a "high level of risk of general offending" could properly be "downgraded" to that of moderate. He gave reasons for reaching that conclusion at paragraph 69. He stated that the doctors reason for reducing the risk was because the appellant's lack of engagement in employment was a factor which elevated the overall risk from moderate to high However, as he concluded that since gaining employment was identified by her at paragraph 7.03 is one of the factors which is likely to reduce his risk of reoffending over time, the FtTJ did not consider that this justified taking a lack of engagement employment out of the risk assessment in order to reduce the assessment of the level of risk from high to moderate. That was a conclusion reasonably open to the FtTJ to reach from the report of Dr P.

105. I consider that where the FT TJ did err in his assessment of the issues is where failed to ask himself whether the type of nonviolent reoffending of which there was a risk was sufficiently serious to constitute a "danger" within the meaning of the Convention and secondly, if it was not sufficiently serious, whether it should be disregarded when determining whether the appellant posed such a risk. As Mr Bundock submitted, the FtTJ failed to provide any analysis or identify any form of "nonviolent"

behaviour which the appellant risked committing which would pass the necessary threshold.

106. Furthermore, there was no consideration of whether any nonviolent, acquisitive behaviour (theft having been identified) which was considered to be conduct of the type that the appellant would be either highly likely to commit or moderately likely to commit, was capable of rendering him as a “danger to the community” so that he should be deprived of protection by the Refugee Convention.

107. Furthermore, whilst the FtTJ made reference to the risk of general reoffending at paragraph [69], beyond noting that it was based on the assumption of continuing to live in supported accommodation, continuing medication and abstinence of drug and alcohol, he made no further analysis of the risk assessment that related to the risk of future violent reoffending.

108. In my judgment, when assessing whether the appellant was a danger to the community it is necessary to consider the appellant’s conduct and behaviour (irrespective of whether it had culminated in being charged and convicted of a criminal offence). If that conduct was likely to be repeated, the appellant would be a danger to the community. It is plain from reading the most recent report of Dr A that the acts or conduct has not been repeated in recent times because his mental health problems have been addressed and he is compliant with treatment. The evidence demonstrated that his current mental health was stable as a result of regular monitoring, treatment with psychiatric medication, being placed on 24-hour monitoring and supported accommodation therefore the risk to others was being managed by the combination of regular psychiatric input and social intervention.

109. But there have been occasions set out in the chronological history where the appellant has not been so compliant and is therefore committed acts and conduct which could probably be described as being a danger to the community. This conduct is again set out in the medical reports relating to threatening and abusive and intimidating behaviour towards others, a history of carrying knives and the use of violence and threats of violence.

110. Therefore, assuming that when his mental health condition is properly managed and he is compliant and he does not commit such acts or conduct, the focus must be on whether it is reasonable to infer that he will continue to cooperate with mental health professionals in light of the history in the past where he did not.

111. To put it another way, when the appellant’s mental condition is managed in the community this requires input from him and if it is lacking it is likely that it would lead to a likelihood of relapse.

112. In my judgment there was no analysis of these issues by the FtTJ in his conclusions at paragraph [70] and I cannot accept the submission made

by Ms Isherwood that the judge did carry out such an analysis either there or overall.

113. In the light of those issues identified I am satisfied that the FtTJ erred in law in his assessment of the issue under section 72 and whether the appellant was a "danger to the community." In the event of an error of law being found Mr Bundock submitted that updated evidence was necessary to address the risk of reoffending/danger to the community given that the last report of Dr P was of some age He also accepted that any resumed hearing would also require consideration of the asserted Refugee Convention ground if the section 72 certificate was not upheld in the light of the FT TJ making no findings or assessment of that issue.

114. There is no appeal against the decision of the FtTJ where he allowed the appeal on Article 3 grounds therefore this remains and is not set aside.

Notice of Decision

The decision of the First-tier Tribunal involved the making of an error on a point of law and is therefore set aside and will be re-made in accordance with the directions sent to the parties.

Direction Regarding Anonymity – Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008

Unless and until a Tribunal or court directs otherwise, the Appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him or any member of his family. This direction applies both to the Appellant and to the Respondent. Failure to comply with this direction could lead to contempt of court proceedings.

Signed

Date 25/9/2019

Upper Tribunal Judge Reeds