Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: PA/12043/2019**

THE IMMIGRATION ACTS

At: Manchester Civil Justice Centre **Decision & Reasons Promulgated**
Heard on the 21 June 2022 **On the 25 October 2022**

Before

UPPER TRIBUNAL JUDGE BRUCE

Between

SA
(anonymity direction made)

Appellant

and

Secretary of State for the Home Department

Respondent

For the Appellant: Mr Holmes, Counsel instructed by WTB Solicitors
For the Respondent: Mr McVeety, Senior Home Office Presenting Officer

DECISION AND REASONS

1. The Appellant is a national of Pakistan born in 1990. He appeals on human rights grounds against the decision of the Secretary of State to deport him.

Background and Case History

2. The Appellant has been in the United Kingdom since he was 21 years old. He arrived in June 2011 with a Tier 4 visa but does not appear to have ever gained any qualifications as a result of his

studies. He overstayed and has been here ever since. He has twice been arrested as an overstayer and served with notification of his liability to removal; in 2016 he claimed asylum but then absconded.

3. Since approximately the summer of 2016 the Appellant has not been well. He has had at least six periods of mental illness which have required inpatient admission under the Mental Health Act 1983; clinicians have given him a "working diagnosis of schizoaffective disorder of the manic type". He has tried to harm himself on a number of occasions: notes released by Pennine Care NHS Trust reveal that he has tried to set fire to his own hospital bed; he has been caught preparing a ligature; he ingested cleaning fluid on the ward; he has been observed smashing his head against a wall; on two occasions he made his way to the roof with the intention of throwing himself off. At present his condition is managed by depot injections. At the date of the hearing before me he was being held under section 48 of the MHA ('under section') in a hospital in the South-East.

4. By her decision dated the 5th November 2019 the Respondent indicated that she intended to deport the Appellant under the powers contained in section 5(1) of the Immigration Act 1971, ie on the grounds that his presence in the United Kingdom is not conducive to the public good. The facts giving rise to that decision are that between May 2017 and March 2019 he committed three crimes. In May 2017 the Appellant received a conditional discharge from Central London Magistrates Court after being convicted of assaulting a person designated/accredited under the Mental Health Act. In October 2017 Minshull Street Crown Court in Manchester sent the Appellant to prison for six months upon his conviction for sending a communication conveying a threatening message: he had telephoned the mental health unit at Stepping Hill Hospital and (falsely) claimed that there was a bomb planted there. In March 2019 he received a caution for cannabis possession. In her letter the Secretary of State took the view that one or more of these offences amounted to a "serious harm offence" justifying deportation action under s5(1).

5. The Appellant appealed on human rights grounds. He relied on both Article 3 and Article 8. The matter came before Judge Curtis of the First-tier Tribunal. By a decision dated the 2nd April 2020 Judge Curtis rejected the Secretary of State's case that any of the offences could be described as having caused 'serious harm'. In the absence of any indication from the Respondent as to which offence might have triggered the deportation action, Judge Curtis understandably focused on the only one to have resulted in a custodial sentence, the bomb threat to Stepping Hill. Having heard detailed evidence and submissions about that matter Judge Curtis concluded that the 'serious harm' threshold had not been met. Although the Appellant's call had no doubt caused inconvenience and alarm, the staff who had taken the call had declined to give victim impact statements, with the implication being that they were "not overly troubled by it". At trial

both members of staff involved indicated that the Appellant had been "extremely distressed" whilst on the phone: "given their experience on the unit, they understood the situation".

6. The Tribunal then turned to the "question of whether the Appellant is a persistent offender", before concluding that he was. Finding deportation action justified on that basis, the Tribunal proceeded to dismiss the Appellant's Article 8 appeal on the grounds that it was a proportionate response to the need to maintain immigration control.

7. The Appellant appealed to the Upper Tribunal on several grounds but in his succinct decision of the 4th February 2021 Upper Tribunal Judge Perkins only found it necessary to focus on two, setting the decision below in the following terms:

> "I am quite satisfied that the First-tier Tribunal erred in law. The fundamental problem is that the judge, for reasons that are not clear, addressed his mind to whether the appellant is a persistent offender. This has never been the Secretary of State's case and it is not clear why this was thought to be relevant. Not only did the judge take the point on his own initiative but he dealt with it wrongly by regarding as convictions things that he should not have regarded as convictions".

By this last sentence Judge Perkins appears to accept the merit in Mr Holmes' submission that Judge Curtis had been wrong, as a matter of law, to count a conditional discharge as a conviction.

8. Judge Perkins directed that the decision in the appeal be re-made after a *de novo* hearing in the Upper Tribunal. Acting Principal Resident Judge Kopieczek signed a transfer order on the 21st March 2022 and following some delay in order that further medical assessments could be conducted, the matter came before me. I heard submissions only from Mr Holmes and Mr McVeety for which I am grateful. Given the terms of Judge Perkins' decision, the appeal proceeded before me on the basis that the reason for the deportation action was that the Secretary of State deemed it to be conducive to the public good.

Discussion and Findings

The Deportation Action

9. Section 3 of the Immigration Act 1971 makes general provisions for regulation and control of immigration. Section 3(5) provides:

> (5) A person who is not a British citizen is liable to deportation from the United Kingdom if—

> (a) the Secretary of State deems his deportation to be conducive to the public good; or
>
> (b) another person to whose family he belongs is or has been ordered to be deported.

10. Section 5 of the IA 1971 Act lays down the procedure for, and further provisions as to, deportation. Sub-section 1 provides:

> (1) Where a person is under section 3(5) or (6) above liable to deportation, then subject to the following provisions of this Act the Secretary of State may make a deportation order against him, that is to say an order requiring him to leave and prohibiting him from entering the United Kingdom; and a deportation order against a person shall invalidate any leave to enter or remain in the United Kingdom given him before the order is made or while it is in force.

11. In Bah (EO (Turkey) – liability to deport) [2012] UKUT 00196 (IAC), the Tribunal held that in 'conducive' deport appeals the first step is to determine whether the material facts asserted by the Secretary of State have been established; then the Tribunal should consider whether, on the facts viewed as a whole the conduct, character or associations of the appellant reach such a level of seriousness as to justify deportation. Only then, if those matters are established, should the Tribunal go on to consider whether the appellant's human rights preclude deportation. Although Bah concerned a previous statutory scheme, the parties before me agreed that this continues to be the correct approach, subject to two caveats. First that the 'level of seriousness' justifying deportation is to be judged against the framework set out in Part 5A of Nationality, Immigration and Asylum Act 2002: RLP (BAH revisited – expeditious justice) Jamaica [2017] UKUT 330 (IAC) (11 April 2017). Second, even if I am not satisfied that the Secretary of State has discharged the burden upon her and shown the Appellant's deportation to be conducive to the public good, I must still determine the proportionality of the decision refusing to grant him leave to remain, given that it is in the public interest that individuals who cannot meet the requirements of the Immigration Rules be removed.

12. Part 5A of the Nationality, Immigration and Asylum Act 2002 now governs the approach to be taken where claimants allege that an immigration decision breaches their rights under Article 8 ECHR. See section 117A:

> **117A Application of this Part**
>
> (1) This Part applies where a court or tribunal is required to determine whether a decision made under the Immigration Acts—
>
> (a) breaches a person's right to respect for private and family life under Article 8, and

> (b) as a result would be unlawful under section 6 of the Human Rights Act 1998.
>
> (2) In considering the public interest question, the court or tribunal must (in particular) have regard—
>
> (a) in all cases, to the considerations listed in section 117B, and
>
> (b) in cases concerning the deportation of foreign criminals, to the considerations listed in section 117C.
>
> (3) In subsection (2), "the public interest question" means the question of whether an interference with a person's right to respect for private and family life is justified under Article 8(2).

13. In cases involving 'foreign criminals' the public interest factors set out at s117C must be taken into account. As to who counts as a 'foreign criminal' this is defined at s117D:

> **117D Interpretation of this Part**
>
> …
>
> (2) In this Part, "foreign criminal" means a person—
>
> (a) who is not a British citizen,
>
> (b) who has been convicted in the United Kingdom of an offence, and
>
> (c) who—
>
> (i) has been sentenced to a period of imprisonment of at least 12 months,
>
> (ii) has been convicted of an offence that has caused serious harm, or
>
> (iii) is a persistent offender.

14. In accordance with the approach in Bah/RLP (Jamaica) I must first consider whether one or more of the three limbs of s117D(2)(c) apply to the Appellant.

15. He has never been sentenced to a period of imprisonment of at least 12 months.

16. In undisturbed findings the First-tier Tribunal concluded that the Appellant has not been convicted of an offence that has caused serious harm. The Secretary of Appeal has filed no challenge to that finding, and in any event I am satisfied that it was correct.

17. Judge Perkins, albeit in very brief reasoning, has explained why the Upper Tribunal does not accept that the Appellant can be termed a

"persistent offender". For the sake of completeness he did so in light of Mr Holmes' written submissions which point out that section 14(1) of the Powers of Criminal Courts (Sentencing) Act 2000 provides that a conditional discharge "shall be deemed not to be a conviction for any purpose other than the purposes of the proceedings in which the order is made and of any subsequent proceedings which may be taken against the offender" following the commission of an offence during the operative period of the discharge. That excludes the first offence, leaving two convictions. I am not satisfied that two convictions, both committed when seriously unwell, justify a finding that the Appellant is someone who "keeps on breaking the law": Chege ('is a persistent offender') [2016] UKUT 00187 (IAC).

18. I am therefore satisfied that the Secretary of State has failed to demonstrate that the Appellant's offending has reached a level of seriousness such that deportation would be justified on the grounds that it would be conducive to the public good.

19. I must nevertheless go on to determine whether the refusal to grant the Appellant leave to remain on human rights grounds is unlawful with reference to s6(1) of the Human Rights Act 1998: "it is unlawful for a public authority to act in a way which is incompatible with a Convention right". The Appellant alleges that two human rights are in play: Article 3 and Article 8. Whilst the legal framework governing those articles is quite different, the factual matrix pertaining to both is the same.

The Facts

20. The Appellant's medical history, and current diagnosis, is set out in detail in a report dated the 15th March 2022 by Consultant Psychiatrist Dr Priyadarshan Joshi. The Secretary of State does not challenge any aspect of Dr Joshi's evidence, but it is relevant to note that Dr Joshi was in charge of the Appellant's care when he 'sectioned' under the Mental Health Act for four months in late 2021 when he saw him at least twice per week and regularly reviewed his condition; he then reviewed the Appellant's medical history and saw him for an in-depth interview (in English and Urdu) for the purpose of preparing his report in February 2022. As such I am satisfied that Dr Joshi is well placed to offer comment on the Appellant's ongoing mental health issues: HA (expert evidence: mental health) Sri Lanka [2022] UKUT 00111 (IAC).

21. As far as Dr Joshi is able to discern the Appellant's personal history is as follows. He reports that he is from a village near Lahore, one of six children. His father died about 18 months ago. His mother remains in Pakistan, and suffers from mental health issues. She talks to herself and "hurls abuse" at people. She does not have access to medications that would manage her psychotic symptoms. The village doctor has prescribed herbal medicine but to no effect. One of the Appellant's sisters has learning disabilities, and he has a brother in

immigration detention in Greece. The report is silent on where the other siblings might be; I take this as an indication that they remain in Pakistan. The Appellant attended school but found it difficult and hated it. The only subject he enjoyed was English. In 2011 he applied for a visa to come to the UK to study it further, but in the end only attended college for three days. The college demanded money for fees that he did not have, so he left and instead started work.

22. The Appellant's first recorded sign of mental illness was in 2016 when a doctor in the immigration detention centre he was then being held in recorded concerns. In July of that year the Appellant was picked up by the police in London where he was found walking barefoot and apparently suffering from auditory hallucinations. He was detained under a section at Roehampton Mental Health Unit but absconded through a window; he was apprehended and transferred to a secure unit, where he made his way to the roof with the stated intention of throwing himself off, prepared a ligature for his neck, and drank disinfectant. He is described as being "very unwell" at that time, with marked psychotic symptoms.

23. In August 2016 he was released to stay with an aunt in the Greater Manchester area. She however then asked him to leave (in his submissions Mr Holmes explained his instructions that this was because of certain problematic behaviours exhibited by the Appellant which his aunt felt could not be tolerated in her household: I infer that this refers to the type of behaviours alluded to at paragraph 26 below). For a period of some months the Appellant was treated with anti-depressants in the community. It was during this period that he made the hoax bomb threat to Stepping Hill, apparently in frustration that they would not tell him what medication he had been given whilst he was detained there.

24. In May 2017 he was again picked up by police in London; he appeared very unwell at this time. In June 2017 his detention under the Mental Health Act was once again ordered, and in the period he was held up to October 2017 he was observed to burn himself with cigarettes, to bang his head against the wall, to tie clothing around his neck, to stab himself in the neck with a paperclip and to smack himself in the face with a shoe. He is recorded as threatening/ attempting to set himself on fire. He was released into the community in October, and was again treated with anti depressants.

25. In July 2018 his condition once again deteriorated and this time following assessment he was given a diagnosis of Schizoaffective Disorder. He was 'sectioned' again between August 2018 and November 2018. He was released into the community but did not engage well with his treatment plan.

26. On the 30th July 2021 he was arrested in a supermarket on suspicion of shoplifting. He was remanded in custody but was soon transferred

to a secure mental health unit where he is recorded as "exhibiting psychotic symptoms, severe neglect of personal hygiene and nutrition, sexualised behaviour and social disinhibition". He was again observed smashing his head against walls and exhibited delusional behaviour. He was for instance convinced that he was being given food that had been tampered with. The Appellant remained held under section at Cobden Unit until November 2021. Dr Joshi reports of this period (when he was the treating physician):

> "Manic symptoms: pressure of speech, overactivity, racing thoughts, elated mood, easy arousal to anger when frustrated, insomnia, grandiose delusions and demeanour. He was very persistently intrusive and demanding. He was socially disinhibited and annoyed other peers who then became hostile to him. He was unable to keep to the Ward boundaries. He was targeting a couple of nurses who he believed had killed him by suffocation during his previous admission to Cobden. He made sudden aggressive movements towards nurses and then laughed at their startled and evasive response. Inappropriate behaviour such as making Facebook requests to nurses in spite of prompts.
>
> Symptoms of psychosis: he reported auditory hallucinations. He listened to verses from the Koran to distract himself from the voices. He believed he was assaulted by another peer in his own bedroom while he was asleep (untrue). He reported incidents where he was variously beheaded or shot in the head or cut up by others (prison officers, prisoners and prison nursing staff etc) and that the blood on the floor had congealed and got back together and he had been reformed or come back to life. He believed that two particular nurses had suffocated him to death during the previous admission to Cobden Unit after they left the room he had come back to life….
>
> Aggression: he showed persistent hostility, aggressive behaviours and disinhibited behaviours. He threw objects at walls threatening to harm nursing staff and peers, attempted to physically harm nursing staff and peers, secreted a fork on two occasions and refused to give it up. He threatened to stab a peer with a fork. he punched a nurse. He often shouted or screamed and would on occasion aggressively run towards the staff and make verbal threats. He lay down in doorways, blocking exits and masturbated when in the presence of staff.
>
> He made shooting gestures or beheading gestures and said that she had a duty to kill kafirs (Non-Muslims or non believers). On one occasion he abruptly tried to overturn a large table on me during the course of a very pleasant conversation. He thought I was laughing at him. A day before this interview he had thrown the phone at the wall and had spat at the nurse who had come to collect the Ward's phone from him.
>
> He was very easily aroused to anger and became aggressive, both verbally and in behaviour. He exhibited unpredictable outbursts of unprovoked aggression and even violence. He would abruptly

> explode into anger in response to real or perceived threats or frustrations he repeatedly required verbal de-escalation, physical restraints and even nursing in seclusion suite during his time on Cobden Unit.
>
> Day to Day Living Skills: [the Appellant's] personal hygiene was very poor and he was malodorous he was unable to budget and would often be without money and tobacco".

27. After over four months in the Cobden Unit the Appellant's symptoms subsided. Although he had residual psychotic delusions, and continued to be angry and irritable, there were less violent outbursts. He was transferred to a low secure unit for rehabilitation work where he spent a further two and a half months before being released into the community in February 2022.

28. Dr Joshi prepared his report in March, and obviously at that stage was unaware that within a matter of weeks the Appellant would once again be 'sectioned' under the Mental Health Act, this time in the south of England. At the time that he saw him for his extended interview he reported that the Appellant was oriented in time, place, person and self, and accepting of the need for medication. He was able to speak to Dr Joshi in a normal tone and volume, and expressed grief at the recent death of his father. He said that he felt guilt at having "let his family down". His problems did however persist. The Appellant insisted that the root of his problems lay with a colleague of Dr Joshi who had prescribed him 'red pills' which had made him unwell; he became agitated and angry about this man and about Pakistani people in London who had mocked and abused him. He described religious based visual hallucinations which he believes to be real.

29. The Appellant is diagnosed with Schizo-affective Disorder, Current Episode Manic with Psychotic Symptoms. This is considered a serious and enduring mental disorder within the meaning of the Mental Health Act. This has been characterised by periods of psychosis, with symptoms such as hallucinations, delusions and thought disorder. Periodically he has presented with severe depressive episodes as well as episodes of mania that are superimposed on his psychotic symptoms. When he has a "relatively well phase" residual psychotic symptoms can persist, or be absent: he has had these periods in spite of non-concordance with his medication and the use of illicit street drugs cannabis and spice. As to cause Dr Joshi notes that the Appellant's history of mental illness would have predisposed him to developing this disorder, which would be compounded by the stress he feels for having failed to provide for his family in Pakistan, his use of spice and cannabis, and the ongoing uncertainty about his future. There is no history of particular trauma.

30. In terms of prognosis, Dr Joshi reports that the Appellant's mental disorder is a chronic, severe mental disorder which is of a relapsing

and remitting nature. There is a high likelihood of him suffering further episodes of his mental disorder in the future. In between episodes he exhibits residual symptoms of his illness; with each episode he is likely to be left with increasing deficits in his level of functioning, ie the number of episodes are likely to correlate with a poorer outcome. He is deemed to have a significantly higher risk of self-harm and suicide because of his mental disorder, substance misuse, impulsivity and lack of social support network.

31. Doctor Joshi is asked to comment on the possible outcome for the Appellant should he be returned to Pakistan. He notes the Appellant's pervasive sense of guilt and stress around having 'failed to provide' for his family; his sense of responsibility as the eldest in his family weighs heavily upon him. He would in Dr Joshi's opinion experience a sense of shame, guilt, failure and hopelessness. Such stressors could trigger a worsening of symptoms and even a relapse into an episode or suicide. Dr Joshi notes the apparent absence of proper care for the Appellant's mother. If treatment is withdrawn it is "highly likely" that the Appellant will experience another relapse. At such times his functioning is greatly compromised. He shows severe neglect of his personal hygiene and appearance and safety, and it is of note that he has only ever got into trouble with the law when he is experiencing symptoms of his mental illness. He is also vulnerable when unwell to exploitation and abuse. He has threatened self-harm, harmed himself and indulged in very risky behaviours such as fire setting, climbing onto the roof and stabbing himself.

32. The Appellant has received treatment in a number of inpatient psychiatric units; he has been assessed by numerous psychiatry specialists, social workers, and specialist nursing staff. None of these clinicians or professionals has at any time expressed a view that he may be feigning or exaggerating his symptoms. His ongoing treatment plan will involve medication, monitoring of side effects and effectiveness, psychosocial support in the community and ongoing monitoring through community mental health teams and outpatients' clinics. Dr Joshi does not believe that there could be an effective treatment plan without these inputs. A change in medication could be possible, but would ideally be offered under close supervision and monitoring.

33. I have also been provided with the results of a multi-disciplinary review conducted by the team at the Psychiatric Intensive Care Unit where the Appellant was being cared for on the 14th June 2022. This records that the Appellant was admitted to the unit on the 27th May after self-presenting with disordered thoughts and responding to hallucinations; he had been sleeping rough, had soiled clothes and hair, and had injured himself by repeatedly burning the soles of his feet with a lighter. At the date of the review he continued to fluctuate in mood and presentation. Although he has exhibited some positive behaviours, for instance attending the gardening group and engaging

by helping to plant trees etc, the Appellant continues to be quite unwell. He can present as chaotic, invading peers personal space. He has been hissing at people and spitting around the ward. He continues to express the belief that people want to kill him. He has been grinding his teeth and making his mouth bleed. He is deemed to lack capacity and is being treated by depot injection.

34. Mr McVeety referred me to the September 2020 Country Policy and Information Note *Pakistan: Medical and healthcare provisions* (v 2). Three themes emerge from the fairly brief section on mental health care.

35. The first is that there certainly is psychiatric care available in Pakistan. Figures provided by the World Health Organisation in 2017 show that there are 11 specialist hospitals, 800 smaller units and 3729 outpatient mental health facilities. There are 400 psychiatrists. The second is that although this care is mainly provided by the public sector, patients are generally expected to contribute something – at least 20% - to the costs of their care and pay for medication.

36. The third is that although mental illness is widespread, it is still regarded as a taboo subject, and not necessarily recognised as a medical illness: "In Pakistani culture, it is commonplace to approach spiritual or traditional healers in cases of physical or mental illnesses. Faith healing is the traditional way of treatment for mental ailments in this culture, as people usually perceive mental illness to be the result of supernatural influences. Use of faith healers is irrespective of socio-economic factors as it usually depends on the person's belief toward spiritual healing. Faith healers are a major source of care for people with mental health problems in Pakistan, particularly for women and those with little education.' [4.12.5]. I note that this accords with a major literature review produced in the Appellant's bundle. The consistent conclusions of 13 different studies conducted between 2000 and 2015 were that most mental health patients visit religious or faith healers first.

37. The CPIN goes on to identify another aspect of this association:

> 4.12.6 Similarly, The News International noted in February 2020 '[S]eeking help for psychological disorders is problematic in Pakistan. Mental illness is often associated with supernatural forces such as witchcraft, possession, and black magic. Families often hide mental illness to prevent the patient from adverse stereotyping.'

38. This evidence is echoed in an in-depth study produced in the Appellant's bundle and published by Cambridge University Press, *Stigma toward mental and physical illness: attitudes of healthcare professionals, healthcare students and the general public in Pakistan* (Husain, Muhammad Omair et al):

> "Mental illness is more stigmatised than physical illness in Pakistan across healthcare professionals, healthcare students and the general public.…A survey of medical students and doctors from Pakistan reported that just over half of the participants held negative attitudes toward people with mental illness. Explanatory models of mental illness with roots in religion and the supernatural are more common in South Asian populations and may contribute to such attitudes. Mental illness in traditional societies is at times thought to be a consequence of social or moral transgressions, and perceived to be divine punishment, demonic possession or sorcery. When an individual suffering from mental illness lives in a society with these perceptions, they are often subject to shame and social exclusion. The social implications of stigma affect the patient and extend to the family, whose entire social status comes under threat. Physical illness is conceptualised as a medical phenomenon, with even somatic symptoms of mental illnesses being considered relatively socially acceptable. However, emotional symptoms are regarded as a sign of weak faith".

39. Similar conclusions are reached in a recent piece of research published in the British Journal of Psychiatry *Crime and punishment: Pakistan's legal failure to account for mental illness* (Khan, RQ and Khan AM, 18 June 2020) which described the Pakistani healthcare system as suffering a 'crisis', with a dearth of infrastructure, overwhelmed physicians and only 0.4% of the overall health budget going on mental health. The article reports that "more recent unofficial reports project the number of psychiatrists to be 500 serving a population of around 200 million (compare to 4500 full time consultants serving the UK population of 65.5 million). Given these figures, it is not surprising that mental health policy faces a crisis in practical implementation". The authors go on to examine the interaction between the mentally unwell and the criminal justice system, citing a number of disturbing cases, for instance people being convicted of crimes committed when they lack capacity. They go on:

> "Perhaps the most sensitive application of mental health laws in Pakistani society comes in conjunction with the application of the blasphemy laws. The Pakistan Penal Code recognises a number of punishments for various degrees of the offence, the harshest one being death under section 295-C. In 2005, Saifullah Khan, who suffered from severe psychosis and delusions, was accused of blasphemy for alleged desecration of the Holy Quran. His appeal for bail was rejected by a Sessions Court despite the Standing Medical Board's confirmation that the accused was 'unfit to plead'. The decision was later reversed by a High Court in 2006. In *Shahbaz Masih v State* in 2007 Masih was acquitted by Lahore High Court on account of having an 'unsound mind', but such success stories are few and far in between. Numerous times the victims have been extracted from police custody by mobs and beaten or burnt to death despite clear evidence of mental illness. In some cases, the blasphemy laws have even been used to frame

> or persecute minorities or individuals with disabilities such as Down's syndrome".

The Law

40. As I set out above, this is no longer a deportation appeal, since the Secretary of State has failed to establish that any of the three alternative routes to establishing that the Appellant's deportation would be conducive to the public good are made out: he has not been sentenced to more than 12 months in prison, his offending has not caused serious harm, and he is not a persistent offender.

41. The question remains, should the Appellant, an overstayer for some 11 years, be granted leave on human rights grounds?

42. There are three avenues open to him to argue that he should.

43. The first is that he could demonstrate that his removal would result in a violation of the United Kingdom's obligations under Article 3 ECHR. The leading authorities on Article 3 and medical issues are Paposhvili v Belgium [2016] ECHR 1113; [2017] Imm AR 867, Savran v Denmark 7 December 2021 (application no. 57467/15) and in the domestic courts AM (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17; [2020] Imm AR 1167. The principles derived from these cases have recently been distilled by the Tribunal in AM (Art 3; health cases) Zimbabwe [2022] UKUT 00131 (IAC) to a series of questions:

> *(1) Has the person (P) discharged the burden of establishing that he or she is "a seriously ill person"?*
>
> *(2) Has P adduced evidence "capable of demonstrating" that "substantial grounds have been shown for believing" that as "a seriously ill person", he or she "would face a real risk":*
>
> *[i] "on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment,*
>
> *[ii] of being exposed*
>
> *[a] to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering, or*
>
> *[b] to a significant reduction in life expectancy"?*
>
> *The first question is relatively straightforward issue and will generally require clear and cogent medical evidence from treating physicians in the UK.*
>
> *The second question is multi-layered. In relation to (2)[ii][a] above, it is insufficient for P to merely establish that his or*

> *her condition will worsen upon removal or that there would be serious and detrimental effects. What is required is "intense suffering". The nature and extent of the evidence that is necessary will depend on the particular facts of the case. Generally speaking, whilst medical experts based in the UK may be able to assist in this assessment, many cases are likely to turn on the availability of and access to treatment in the receiving state. Such evidence is more likely to be found in reports by reputable organisations and/or clinicians and/or country experts with contemporary knowledge of or expertise in medical treatment and related country conditions in the receiving state. Clinicians directly involved in providing relevant treatment and services in the country of return and with knowledge of treatment options in the public and private sectors, are likely to be particularly helpful.*

44. I note that a finding in his favour on this matter would hold even if I am wrong about the deportation argument.

45. Next there is Article 8 as it is codified in the Immigration Rules. Paragraph 276ADE(1) of the Rules provides four alternative routes for migrants seeking leave to remain on the grounds of their Article 8 private lives. Only one, here highlighted in bold, might conceivably apply to the Appellant:

> 276ADE (1). The requirements to be met by an applicant for leave to remain on the grounds of private life in the UK are that at the date of application, the applicant:
>
> (i) does not fall for refusal under any of the grounds in Section S-LTR 1.1 to S-LTR 2.2. and S-LTR.3.1. to S-LTR.4.5. in Appendix FM; and
>
> (ii) has made a valid application for leave to remain on the grounds of private life in the UK; and
>
> (iii) has lived continuously in the UK for at least 20 years (discounting any period of imprisonment); or
>
> (iv) is under the age of 18 years and has lived continuously in the UK for at least 7 years (discounting any period of imprisonment) and it would not be reasonable to expect the applicant to leave the UK; or
>
> (v) is aged 18 years or above and under 25 years and has spent at least half of his life living continuously in the UK (discounting any period of imprisonment); or
>
> **(vi) subject to sub-paragraph (2), is aged 18 years or above, has lived continuously in the UK for less than**

20 years (discounting any period of imprisonment) but there would be very significant obstacles to the applicant's integration into the country to which he would have to go if required to leave the UK.

46. 'A very significant obstacle to integration' means something which would prevent or seriously inhibit the applicant from integrating into the country of return. I must look for more than mere obstacles. 'Very significant' indicates that this is a high threshold. It is a test that would certainly be met if the Appellant could demonstrate that removal to his country of nationality would result in an irreparable nullification of his private life, ie he would be unable to establish a private life in Pakistan, but this is not the threshold. 'Very significant obstacles' will also exist where an applicant demonstrates that establishing a private life in the country of return would entail 'very serious hardship'.

47. 'The idea of "integration" calls for a broad evaluative judgment to be made as to whether the individual will be enough of an insider in terms of understanding how life in the society in that other country is carried on and a capacity to participate in it, so as to have a reasonable opportunity to be accepted there, to be able to operate on a day-to-day basis in that society and to build up within a reasonable time a variety of human relationships to give substance to the individual's private or family life' Secretary of State for the Home Department v. Kamara [2016] EWCA Civ 813 (11 August 2016) [2016] 4 WLR 152. In AS v. Secretary of State for the Home Department [2017] EWCA Civ 1284 (23 August 2017) [2018] Imm AR 169 the Court of Appeal held that "consideration as to obstacles to integration requires consideration of all relevant factors, including generic ones such as intelligence, employability and general robustness of character".

48. Finally the Appellant argues that the refusal to grant him leave to remain is unlawful under s6 HRA 1998 because it would be a disproportionate interference with his private life rights. Even if he fails on the grounds of Article 3 and paragraph 276ADE(1) he could still succeed if he can show that in all the circumstances of his case, his removal is nevertheless unreasonable. This evaluation would include matters not taken into account thus far, namely the life he has in the UK: here that would involve positive matters in his favour, such as a therapeutic relationships he has with his clinicians, and matters weighing against him, including his criminality and all of the 'public interest' factors set out at s117B of the Nationality, Immigration and Asylum Act 2002.

Discussion and Findings

49. The first question posed in AM (Zimbabwe) is has the Appellant discharged the burden of establishing that he is "a seriously ill

person"? The answer, unequivocally, is yes. I need not set out my reasoning in detail here, since the Secretary of State accepts that conclusion, but would point to the uncontested evidence that the Appellant has tried to kill or otherwise harm himself on several occasions and has been diagnosed with a condition categorised by the NHS, and the Mental Health Act, as a "serious and enduring mental disorder".

50. The second, composite, question is whether or not he has established that there are substantial grounds for believing that if returned to Pakistan he would face a real risk of being exposed to a serious, rapid and irreversible decline in his state of health resulting in intense suffering, or even to a significant reduction in life expectancy"? This question is, as the Tribunal observe in AM, "multi layered". It is insufficient for the Appellant to merely establish that his condition will worsen upon removal or that there would be serious and detrimental effects. What is required is "intense suffering".

51. To my mind there are three factors that are particularly relevant to this enquiry.

52. The first is the accessibility or otherwise of healthcare in Pakistan. Mr Holmes wisely conceded that there are psychiatric facilities in Pakistan, and that the anti-psychotics that the Appellant has been prescribed in the UK are also available there. The evidence indicates that such facilities that do exist are however woefully inadequate to meet demand. The article I was referred to in the British Journal of Psychiatry (BJP) referred to the situation as a "crisis" and nothing I have been referred to in the CPIN gainsays that description. The World Health Organisation figures from 2017 show that in that country of approximately 200 million people there are 11 specialist hospitals (all in major cities), 800 smaller units and 3729 outpatient mental health facilities, but only 400 psychiatrists: even if the higher figure of 500 given in the BJP article is preferred, it nevertheless illustrates the inadequacy of the provision for a population of that size. Even in the public sector patients are required to pay something towards their care. I extrapolate from this information that it is *possible* to get psychiatric care in Pakistan but certain factors will confer an advantage on you in doing so: living in or being able to travel to the city, having money and being determined.

53. None of those factors apply to the Appellant. His family home lies in a village, and it would appear from all of the evidence that his family are in a difficult financial position. I say this not only because of the weight of expectation that the Appellant himself carries – that as a migrant he was supposed to provide for his family - but because of what has happened to his mother. Although she has been unwell herself for a number of years, it is his understanding that no one has ever taken her to the city for psychiatric treatment, nor paid for her to have medication that might help her. She has remained in the village

where she talks to herself and "hurls abuse" at people. I infer from this evidence that there is no one left in Pakistan who has the will, or wherewithal, to obtain care for her from one of the health centres or hospitals mentioned in the CPIN. It is against that background that I evaluate the likelihood of the Appellant managing to do so.

54. This is a man who has been extremely unwell since 2016. Even during periods where he has been relatively stable he has continued to rely on medical and social services in this country for medication, housing and support. The history provided by Dr Joshi over the past six years is characterised by severely psychotic episodes interspersed – following treatment – by "relatively well" periods where the Appellant is still suffering from severe depression in the community. I note that in his longest period out of a secure unit (between November 2018 and July 2021) the Appellant was found not to be concordant with his medicine regime, and did not engage well with his treatment plan. By July 2021 when he was once again sectioned he was found to have severely neglected his own personal care and was exhibiting extreme psychotic symptoms. His frequent, and lengthy, periods of treatment under section illustrate not only the severity of his condition, but that he needs specialist, inpatient intensive care before he is well enough to be released again into the community. As Dr Joshi makes clear, this is not simply a matter of taking a pill, or accepting an injection. The Appellant has not, as far as I am aware, worked in some years. Staff on the Cobden Unit, where he was held under section during 2021, noted that he is unable to budget and is often without money. He has had periods of street homelessness. In the most recent report that I have, from those who were caring for him in Kent earlier this year, he is deemed to lack capacity and is being treated with depot injections. Mr Holmes submitted that on those facts I can reasonably conclude that this is a man who is extremely unlikely to be able to push himself to the front of the queue in order to access effective mental health treatment in Pakistan. I agree. Unlike the appellant in AM (Zimbabwe), this is an individual who does not have a choice. His illness is such that he does not have the capacity required to be able to navigate a system which is underfunded, where demand outstrips supply, where money is required and where he would physically need to travel in order to access support. The chances of him going without treatment in Pakistan are in my view high.

55. The second external factor, if I might put it like that, is the prevalence of negative social attitudes towards mental ill health in Pakistan. All of the evidence before me consistently reports that those who suffer from the kind of illnesses that the Appellant lives with are subject to a lack of understanding at best, and serious societal discrimination at worst. Although mental illness is as widespread in Pakistan as it is anywhere else, it is still regarded as a taboo. Many people regard mental illness as a spiritual deficiency, or as the result of supernatural influences such as witchcraft. Faith

healers – or as in the case of the Appellant's mother, herbalists – are the first, and only port of call for many. Families resort to concealing mental illness in order to prevent the sufferer from such adverse stereotyping. As Husain et al put it: "mental illness in traditional societies is at times thought to be a consequence of social or moral transgressions, and perceived to be divine punishment, demonic possession or sorcery". People who are suffering from mental ill health can accordingly be stigmatised, feared, mocked and abused. I note that the Appellant has experienced responses consonant with that evidence in his interactions with members of the Pakistani community in this country. He reported to Dr Joshi being mocked by Pakistani men in London, and was asked to leave the home of his aunt because of what she regarded as unacceptable behaviours. Dr Joshi lists some of those behaviours during 2021 as including smashing his head against walls, talking incoherently about matters of religion, shouting, screaming and threatening people, running at people aggressively, throwing objects, severely neglecting his own personal hygiene and masturbating in public.

56. I am extremely concerned about the consequences for the Appellant should he exhibit such behaviours in public in Pakistan. His mother, an older woman, may be secluded in the house and subject to no more than ignorance or cruel whispers. A relatively young man such as the Appellant, however, who is "very easily aroused to anger" and who exhibits "unpredictable outbursts of unprovoked aggression and even violence" is in a completely different position. Someone who talks incoherently about The Qur'an, or having visions, or who masturbates in public, is in my view at a real risk of serious harm in Pakistan where a lack of understanding about mental illness goes hand in hand with a deep religious conservatism: as Khan and Khan report, on numerous occasions "victims have been extracted from police custody by mobs and beaten or burnt to death despite clear evidence of mental illness".

57. The third factor is internal: it is the nature of the Appellant's illness itself. The prognosis is that the Appellant suffers from a chronic, severe mental disorder which is of a relapsing and remitting nature. There is a high likelihood of him suffering further episodes of his mental disorder in the future. In between episodes he exhibits residual symptoms of his illness; with each episode he is likely to be left with increasing deficits in his level of functioning, ie the number of episodes are likely to correlate with a poorer outcome. Dr Joshi concludes that "he is deemed to have a significantly higher risk of self-harm and suicide because of his mental disorder, substance misuse, impulsivity and lack of social support network". Asked to comment on the possible outcome for the Appellant should he be returned to Pakistan, Dr Joshi expresses the opinion that the Appellant's pervasive sense of guilt at having let his family down would give rise to feelings of shame, guilt, failure and hopelessness. Such stressors could trigger a worsening of symptoms and even a

relapse into a psychotic episode or suicide. Dr Joshi states that if treatment is withdrawn it is "highly likely" that the Appellant will experience another relapse. It is when he is at his most unwell that he is a risk to himself and others.

58. I have considered all of those three factors. Having done so I am satisfied that the Appellant has adduced evidence capable of demonstrating that there are substantial grounds for believing that he would, if returned to Pakistan, face a real risk, on account of his lack of access to appropriate treatment, to being exposed to a serious, rapid, and irreversible decline in his state of health resulting in intense suffering. He is without medication "highly likely" to experience a relapse and I am satisfied that this would be extremely distressing, frightening and degrading for him. It would expose him to the real risk of serious harm at the hands of mobs or individual members of the public who are afraid of, and so hostile to, those suffering from psychotic symptoms such as those consistently exhibited by the Appellant. Although the latter point is a risk that is certainly relevant to the AM (Zimbabwe) framework for enquiry, entailing as it does "intense suffering", I stress that it is also a finding that would justify allowing the appeal on more traditional Article 3 grounds. There would only need to be one instance of significant violence aimed at the Appellant to be a violation of the absolute prohibition on torture or inhuman or degrading treatment.

59. Without more information I am unable to say that he would end up destitute. Although Mr Holmes was able to point to his aunt throwing him out of her home in the UK, it would appear from the evidence that the family in Pakistan have not abandoned their mother. For the reasons set out above I have not however found it necessary to explore this point further.

60. In light of my findings it is not necessary to go on to deal with Article 8, so I will do so only in the briefest of terms. If the factors I have outlined above in some way fall short, contrary to my conclusions, of a violation of Article 3, then they would with certainty amount to "very significant obstacles to integration". I am satisfied that the combined factors of the Appellant's illness, the stigmatisation he would face in Pakistan and the obstacles he would face in accessing appropriate treatment would cumulatively prevent him from establishing any kind of meaningful private life in that country. The rule does not require me to conduct a comparison with the private life that the Appellant may have created here. I am simply tasked with assessing whether there are very significant obstacles to his creating a private life, in all its forms, on arrival there. I am satisfied that his illness would operate as a barrier to him finding work, it would place him at the very least (and if I am wrong about the risk of violence) to a real risk of stigmatisation and discrimination. Given the social mores governing mental ill health, and the serious and prolonged nature of his illness, I cannot see that there is any

hope for the Appellant at all to live any kind of normal life in Pakistan. Even if his family provide him with shelter and food he will exist only on the very margins of society.

Anonymity

61. This decision turns on medical evidence about the Appellant. Having had regard to the contents of *Guidance Note 2022 No 2: Anonymity Orders and Hearings in Private* I am satisfied that it would be appropriate to make an order for anonymity in the following terms:

> "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, any of his witnesses or any member of his family. This direction applies to, amongst others, both the Appellant and the Respondent. Failure to comply with this direction could lead to contempt of court proceedings"

Decision and Directions

62. The decision of the First-tier Tribunal is flawed for error of law and it is set aside.

63. The appeal is allowed on human rights grounds.

64. There is an order for anonymity.

Upper Tribunal Judge Bruce
2nd October
2022