**IN THE UPPER TRIBUNAL**
**IMMIGRATION AND ASYLUM CHAMBER**

Case No: UI-2022-004930

First-tier Tribunal No:
HU/02303/2021

**THE IMMIGRATION ACTS**

**Decision & Reasons Issued:**
**On 17 September 2023**

**Before**

**THE HON. MRS JUSTICE HILL**
**UPPER TRIBUNAL JUDGE BLUNDELL**

**Between**

**JOACHIM CARDOS**
**(ANONYMITY DIRECTION NOT MADE)**

Appellant

**and**

**SECRETARY OF STATE FOR THE HOME DEPARTMENT**

Respondent

**Representation:**

For the Appellant: Mr P Haywood, Counsel, instructed by CB Solicitors
For the Respondent: Mr J Holborn, Counsel, instructed by the Government Legal Department

**Heard at Field House on 19 July 2023**

**DECISION AND REASONS**

## Introduction

1. The Appellant is a national of the Gambia. Having entered the UK in 2007, in October 2011 he was convicted of assault, rape and being involved in the supply of a controlled drug. On 28 January 2019 he was served with a deportation order and decision refusing his human rights claim by the Secretary of State for the Home Department ("the SSHD"). A further decision

was made refusing his human rights claim. The Appellant appealed to the First-tier Tribunal ("FtT").

2. By a decision promulgated on 19 April 2022, Resident Judge Holmes and FtT Judge Karbani ("the panel"), allowed the Appellant's appeal on Article 3, ECHR grounds. The SSHD now appeals that decision. For ease of reference we continue to refer to the Appellant as such, as he was before the FtT.

## The factual background

3. The Appellant was born on 6 March 1980. He entered the UK lawfully under a visitor visa valid from 28 June 2007 to 28 December 2007. He informed the SSHD that he wished to join the British Army as part of that entry clearance application and subsequently his leave to remain in the UK was extended until 28 June 2008. Thereafter he was present in the UK unlawfully.

4. On 24 October 2011 after a trial the Appellant was convicted of assault, rape and being concerned in the supply of a controlled drug. On 15 August 2012 at the High Court of Justiciary in Edinburgh he was sentence to an immediate term of imprisonment, comprising 8 years for the rape, 3 years for the supply of drugs, to run consecutively, with a further extension of 4 years for the protection of the public.

5. The Appellant initially served his sentence of imprisonment at HMP Dumfries. However on 7 November 2012, he was transferred to The State Hospital, Carstairs under the provisions of the Mental Health Act 1983, section 47/49 because of concerns over his mental state. On assessment he was diagnosed with paranoid schizophrenia. He was detained in hospital for nearly six more years, until 31 October 2018. It was only when his condition was considered to be both controlled and stable that he was returned to HMP Dumfries to complete his sentence.

6. On 4 March 2019 the Appellant was transferred to immigration detention at Morton Hall IRC. He remained in immigration detention upon completion of his custodial sentence.

7. On 11 September 2018 the Appellant was served with a notice of intention to deport him. On 10 October 2018 he submitted his representations. On 28 January 2019 he was served with a deportation order together with the SSHD's reasons for her decision to treat those representations as a human rights claim and to refuse it. The Appellant appealed that decision.

## The FtT hearing and decision

8. The appeal was heard on 9 March 2022. The Appellant was treated as a vulnerable witness in accordance with the Joint Presidential Guidance No 2 of 2010: Child, Vulnerable Adult and Sensitive Appellant Guidance. The Appellant's appeal was advanced as an Article 3 health claim; alternatively as an Article 8 claim: see [9] of the decision.

9. At [18] of their decision, the panel set out the Upper Tribunal's summary of the law in relation to Article 3 health cases in MY (Suicide risk after Paposhvili) [2021] UKUT 00232 at [12]-[21] in full. This included reference to Paposhvili v Belgium (41738/10); [2017] Imm. A.R. 867, the Supreme Court's consideration of that case in AM (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17; [2020] 2 WLR 1152), Savran v Denmark (57467/15); [2021] ECHR 1025 and the various domestic cases considering the application of Paposhvili to cases involving the expulsion of a criminal with psychiatric conditions. At [19] the panel quoted Savran at [124]-[138].

10. The central issues on the appeal related to the treatment the Appellant would receive for his mental health in the Gambia. He has been prescribed a monthly depot injection of paliperidone to treat his paranoid schizophrenia since 2012/2013, such that his mental condition has been stable. The SSHD accepted in the appeal that depot injections of paliperidone, or risperidone, would not be available to the Appellant in the Gambia: see the decision at [41]-[52].

11. The SSHD's proposal was that the Appellant would change from paliperidone administered by depot injections to risperidone in tablet form; that the change in medication would be effected at or about the point of removal; and that any necessary monitoring of the Appellant's condition and response to the change of medication would take place in the Gambia. Further, the SSHD proposed to provide the Appellant with a physical supply of risperidone tablets, and the metformin he takes for his diabetes, sufficient to last for three months at the point of removal; together with a sum of money which would be sufficient to cover the cost of purchasing both drugs from local pharmacies for a further nine months. He would also be provided with £1,250 through the Facilitated Removal Scheme if he agreed to his removal. The SSHD envisaged that after the initial 12 month period, the Appellant would be able to purchase any medicine and medical treatment he required from his own earnings, having secure employment in that time: see the decision at [43]-[53].

12. The panel made detailed findings on the following topics: the level of support the Appellant might expect from his family if he returned to the Gambia ([23]-[32]); societal support in the Gambia ([33]-[34]); the Appellant's mental health diagnosis ([35]-[38]); his current medication ([39]-[41]); the SSHD's proposal concerning the Appellant's medication in the Gambia (42]-[54]); the Appellant's compliance with his prescription medication regime ([55]-58]); access to medicine, medical treatment and clinical supervision in the Gambia and the risk of the Appellant's relapse into psychosis ([59]-[68]); and the consequences of the Appellant suffering such a relapse ([68]-[70]).

13. The panel concluded that (i) the Appellant is likely to be institutionalised having been detained since October 2011; (ii) there is a real risk that the Appellant will experience genuine difficulties in the Gambia in being able to access a regular supply of his necessary medications; (iii) there is a real risk that in the Gambia the Appellant will fail to take oral medication on a consistent and regular basis; (iv) if he were well and had full insight into the necessity for it he would be able to gain access to a pharmacist and to a

general practitioner in the Gambia, although he would have to pay for it; (v) he would have considerably more difficulty in accessing a psychiatrist because the demand within the community far exceeds the available resource; (vi) historically changes in the Appellant's behaviour have been noted by staff at the various institutions in which he has been held rather than by the Appellant seeking help of his own volition, such that symptoms of relapse in the Gambia would be apparent to third parties before the Appellant; and (vii) if symptoms of relapse were apparent to members of the community but not the Appellant, then there is a real risk of at least social isolation and stigmatisation of the Appellant: see [72]-[77] of the decision.

14. Further, the panel concluded that (i) the Appellant would face real difficulties in finding employment in the Gambia at a wage that will allow him to support himself adequately and permit him to access the medication and healthcare that he needs for the rest of his life; (ii) even if he did find employment, there is a real risk that he would lose it in the event of any interruption to his antipsychotic medication and the development of symptoms of relapse to his condition; (iii) there is a real risk that he would be unable to manage the necessary budgeting to ensure that the finance provided to him by the SSHD during the first 12 months would meet his needs; (iv) accordingly there is a real risk that the Appellant would fall into destitution; (v) there is a real risk that even if he was compliant with the medication he had physically been provided by the SSHD for months 1-3, he would cease to be so compliant and fail to secure either the medication or the professional monitoring that he would require: see [78]-[80] of the decision.

15. The panel found that (i) after some 14 years' absence from the Gambia and without any contact in the interim, the Appellant had not retained ties of friendship with any third parties who may be able to offer him practical support on his return, even if he could locate any old friends; (ii) the Appellant has the ability to look for his siblings and though he has not had contact with his sister since 2012 or his brothers since 2008, if they continue to live in the same region he would be able to find them if he chose to make the effort to do so; and (iii) even if they initially agreed to offer him accommodation and support in monitoring his drug regime, there is a real risk that they would not continue to do so if his mental health deteriorated: see [81]-[83] of the decision.

16. The panel then held as follows:

> "84. Absent family or social mechanisms to identify a deterioration and respond to it by seeking medical intervention, there is in our judgement no effective safeguard against any deterioration in mental health running its course into a full relapse into full psychosis. The proposal to deliver to the Appellant at the point of return a physical supply of three months prescription medication, and thereafter to limit support to a grant sufficient to finance the purchase of a further nine months prescription medication, and the FRS grant, fails properly to engage with the Appellant's circumstances and his health care needs. There is no proposal to put in place any

> systems to ensure the delivery of any necessary medication to healthcare professionals in the Gambia who will in turn supply the [A]ppellant with those medications and/or monitor his dose and response. There is no proposal to ensure any system to monitor the Appellant's response to a change in medication. There is no proposal to alert the authorities to the high risk the Appellant poses to others in the event of relapse.
>
> 85. Accordingly we are satisfied that there is a real risk that in the event of any relapse the Appellant would be unwilling or unable to access suitably qualified healthcare professionals and thus access the medication and treatment that would be required to prevent the relapse accelerating. If he did not seek help, or suitable help was not available to him at the point that he needed it, then we are satisfied that there is a real risk that the responses of the community to the symptoms of his psychosis would be likely to lead to a real risk of a breach of his Article 3 rights. It is in our judgement obvious that were he perceived to be aggressive or violent, then there is also a real risk that the response that he would receive from some members of any society would be violence. Moreover if the Appellant's psychosis did develop to the point that the authorities responded by admitting him to the only facility for those suffering such a condition (Tanka Tanka), and detaining him there, then we are satisfied that there is a real risk that the conditions in which he would be held at that facility would be likely to breach his Article 3 rights".

17. At [86] the panel dismissed the SSHD's argument that even if the Appellant's mental health were to deteriorate that would be a reversible deterioration, and thus it would fail to meet the test set out by the Supreme Court in AM (Zimbabwe) (see further at [36] below).

18. At [87] the panel reminded themselves of the approach of the Supreme Court in AM (Zimbabwe) and of the Grand Chamber in Savran, and that the Paposhvili test is sufficiently flexible to encompass "the direct effects of an illness as well as its more remote consequences", so that a decline in health can be linked to intense suffering, requiring a holistic assessment to be made. The panel confirmed that they were satisfied on the facts of this case that the Appellant's removal to the Gambia "exposes him to a real risk of a serious, rapid and irreversible decline in his state of health resulting in intense suffering and destitution". The panel confirmed that it was this, rather than a demonstration of a significant reduction in life expectancy, that established a real risk of a breach of his Article 3 rights.

19. At [88] the panel turned to the final phase of the structured approach advocated in AM (Zimbabwe), namely the assurances that had been obtained from the receiving state to ensure that appropriate treatment will be available and accessible. The panel noted that the SSHD had made no inquiry into the Appellant's family in the Gambia; had not sought to warn the authorities in the

Gambia of his psychosis and health needs or the risk he may pose to others; had sought no assurances from the Gambia about the medical care that would be available to the Appellant's upon return; and had failed to engage with the authorities in the Gambia or indeed any healthcare providers in the Gambia to ensure that his health care needs could be met adequately in the event of return. The panel concluded that "[t]he reality is therefore that the Respondent proposes no systems or safeguards to ensure that the Appellant's health is monitored adequately, or to ensure reliable access to the necessary prescription medications, or, compliance with his medication regime".

20. For these reasons the panel concluded that the Appellant's human rights appeal succeeded on Article 3 grounds.

21. The Appellant sought permission to appeal on four grounds, namely that the panel had (1) failed to apply the threshold in Paposhvili; (2) failed to consider whether any risk of destitution was causatively linked to the removal decision; (3) reversed the burden of proof; and (4) made a material error of fact relating to the Appellant's anticipated monthly medical expenses.

22. On 18 January 2023 permission was granted by Upper Tribunal Judge Gill.

**The appeal hearing**

23. The SSHD relied on her grounds and skeleton argument, the submissions in which were further developed orally by Mr Holborn. The Appellant relied on his detailed rule 24 response dated 6 July 2023, drafted by Mr Haywood, who also made oral submissions.

**Submissions and discussion**

24. Mr Holborn characterised the SSHD's proposals for the Appellant's return to the Gambia, set out at [11] above, as providing an "extraordinary" level of support. He accepted that if the Appellant had to be admitted to Tanka Tanka, rather than merely visiting it as an out-patient, this would amount to a breach of his Article 3 rights.

***Ground 1***

25. Under this ground, the SSHD argued that the panel had failed properly to apply the Paposhvili threshold test.

26. In Savran the Grand Chamber reiterated the test as follows:

> "134. Firstly, the Court reiterates that the evidence adduced must be "capable of demonstrating that there are substantial grounds" for believing that as a "seriously ill person", the applicant "would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in

> intense suffering or to a significant reduction in life expectancy"…
>
> 140…it is only after that test is met that any other questions, such as the availability and accessibility of appropriate treatment, become of relevance".

27. Mr Holborn's overarching submission was that although the panel had cited the relevant law, they had failed properly to address this threshold question; and had given insufficient reasons to show that the law had been properly applied. However, we agree with Mr Haywood that it is necessary to read the panel's extremely detailed decision as a whole. The panel took care to set out the relevant legal principles, including those from Savran which neither party had cited. The panel approached their factual findings in a careful, thematic way. It is against that backdrop that we consider Mr Holborn's more specific submissions.

28. First, Mr Holborn contended that it cannot be assumed that the consequences of a relapse in psychosis automatically meets the minimum threshold of severity.

29. However, the panel specifically acknowledged at [87] that a "mere diagnosis of schizophrenia is not considered of itself… sufficient to raise a breach of Article 3", and expressly found that "this is not such a case".

30. The panel's assessment in this regard was supported by expert evidence from several doctors about the specific features of the Appellant's illness.

31. At [35]-[36], the panel set out the evidence of the Appellant's experiences when his mental health had deteriorated previously. He had suffered olfactory hallucinations (believing the gas was on or that he was suffering smoke poisoning), and had heard voices threatening to kill him and telling him to hurt others. He had experienced tactile hallucinations, seen humans with tails and things on or in the walls and had night terrors. He had believed his food was being tampered with and that he was being drugged, so he was refusing to eat and drink. He had believed the prison officers wanted to have sex with him and that rituals and sacrifices were being conducted in the showers so that magic was being used against him. He had also suffered delusions of reference.

32. At [67] the panel referred to the Appellant's account to Dr Isherwood of his "relapse signature", namely the signs that he would know he was becoming unwell again. These included nightmares, increased anxiety, hallucinations and experiencing "spiders in his body". He referred to previous experiences of not eating as he believed his food was being poisoned by magic and not showering as he believed there were sacrifices being conducted in the showers.

33. The panel had also considered a December 2020 report under Rule 35 of the Detention Centre Rules 2001, from the Consultant Psychiatrist at Harmondsworth IRC, which supported the picture summarised above. This was

to the effect that the Appellant's paranoid schizophrenia was a "major mental illness diagnosis" which had led to him experiencing "psychotic symptoms such as auditory and tactile hallucinations, and paranoid beliefs", before he was transferred to The Carstairs and placed on depot medication.

34. At [77] of the decision the panel concluded that there was no reason to assume that if the Appellant relapsed in the future, his illness would manifest itself differently to how it had before.

35. We therefore consider that when the panel's decision is read as a whole, it is clear that they fully understood the details of the Appellant's mental health diagnosis; they had carefully considered what the risk of relapse, and remaining untreated in the community in the Gambia, was likely to mean for his mental state; and they had justifiably found that this met the Paposhvili threshold.

36. Second, Mr Holborn submitted that even if there was a real risk of a "serious" and "rapid" decline in the Appellant's mental health, there was no evidence that the panel had considered whether any such decline would be "irreversible". Dr Isherwood's evidence was that medication could be re-started for the Appellant if he stopped taking it. However, the panel specifically addressed the SSHD's argument as to "reversibility" at [86], but rejected it on the basis that it rested upon a misplaced assumption that the Appellant would be able to access healthcare to reverse the deterioration before it reached the point at which there was a real risk that his Article 3 rights had been breached. In our judgment this conclusion was fully grounded in the panel's findings about the lack of availability of proper mental health care for the Appellant, both in terms of access to medication and access to a system of supervision to ensure he took it.

37. Third, Mr Holborn argued that there was no evidence of a real risk that the Appellant would be admitted to Tanka Tanka. We disagree. Professor Knorr's unchallenged evidence was that those suffering from mental health disorder in the Gambia are often "dropped to facilities" by their families: [33] of the decision. More specifically, Dr Kashmiri had explained that in the event of a relapse, the Appellant was likely to require "hospitalisation, supervision and support to ensure he remains well": [68] of the decision. The panel was therefore entitled to conclude as they did at [85] that the Gambian authorities might well respond to a relapse into psychosis by admitting him to Tanka Tanka. Such admission involved a real risk that the conditions in which he would be held would breach his Article 3 rights, because those conditions were likely to involve him being chained up, having no legal redress to challenge a wrong certification or diagnosis, no access to reviews or appeal procedures and facing real risk of admission leading to indefinite detention: [69] of the decision.

38. Fourth, Mr Holborn took issue with the panel's findings at [77] and [85] that if the Appellant relapsed, he faced the risk of social isolation, stigmatisation and violence in the Gambia.

39. The panel had found, based on the Appellant's previous experiences of deterioration, that in the Gambia symptoms of relapse would be apparent to third parties before the Appellant, and that the external expressions of his illness on relapse would include "violence, aggression, distress and hallucinations": [77] and [78] of the decision. These were entirely justified findings in light of the expert evidence and the Rule 35 report, which had referred to the risk of "aggression, violence and further offending behaviours" by the Appellant that would be detrimental to the "safety of others".

40. Mr Holborn relied on the facts of Savran, where the Grand Chamber held at [143] that a relapse in the applicant's schizophrenia which might lead to aggressive behaviour and a risk of harm to others could not be described as resulting in intense suffering for the applicant himself: a risk of aggression to others did not therefore directly engage Mr Savran's own Article 3 rights. However, we are satisfied that the Appellant's case was advanced, and accepted by the panel, on a different basis: namely that the Appellant would be at risk of violence from others because of his behaviour, or as retribution as a consequence of his actions, which might include violence (when he was being paranoid or suffering from delusions) towards them.

41. He argued that the panel had not considered whether this treatment by the community would meet the minimum standard of severity required by Paposhvili. However, the panel had accepted Professor Knorr's evidence to the effect that those suffering from mental health disorders in the Gambia are "heavily stigmatised, often expelled from their families and communities… branded as witches…associated with evil forces…seen as sources of shame and will be locked up in their homes"; that they "suffer physical violence" and "cleansing rituals": [33] of the decision. The panel's finding at [77] that the Appellant was at risk of suffering social isolation and stigmatisation was entirely grounded in the evidence. We consider that the panel's further conclusion, at [85], that if the Appellant was perceived to be aggressive or violent, he would suffer violence in response, was also entirely logical.

42. We are therefore satisfied that the panel concluded that all these elements of the likely community response to the Appellant's relapse met the Paposhvili threshold, and that they were entitled to do so. However, it is clear that this was only one aspect of the panel's Article 3 conclusion, which was justified on other grounds, namely the deterioration in the Appellant's own mental health and the risk of admission to Tanka Tanka, as discussed at [28]-[37] above.

43. In conclusion, we note that the panel correctly directed themselves that the Paposhvili test is sufficiently flexible to encompass the direct effects of an illness as well as its more remote consequences, so that a decline in health can be linked to intense suffering, requiring a "holistic assessment" to be made: [85]. For the reasons given above we are satisfied that the panel properly

conducted this assessment, considered whether the Paposhvili threshold was met, and was satisfied that it was. For these reasons, we dismiss this ground of appeal.

***Ground 2***

44. The SSHD contended that the panel had failed to consider the requirement for a causal link between the decision to remove and any intense suffering feared by the returnee.

45. The need for such a link in an Article 3 "living conditions" case has recently been emphasised by the Upper Tribunal in OA (Somalia) v SSHD [2022] UKUT 33 (IAC). There, the Tribunal held that there is a requirement for temporal proximity between the removal decision and any "intense suffering" of which the returnee claims to be at real risk; and that a returnee fearing "intense suffering" on account of their prospective living conditions at some unknown point in the future is unlikely to be able to attribute responsibility for those living conditions to the SSHD, for to do so would be speculative.

46. Mr Holborn submitted that the panel had not grappled with the issue of whether the hypothetical consequence of a relapse, namely destitution (see [78] and [87] of the decision), was too remote or speculative to establish the requisite causal link; or whether such a consequence would be insufficiently proximate in time given the SSHD's proposal to ensure provision of medication and funding for a period of a year. Again, he argued that the panel had given insufficient reasons to show that the law had been properly applied.

47. We disagree. The panel found at [78] that the Appellant was likely to "spiral into destitution", on the basis that even if he did find employment (which they concluded he would face "real difficulties" in doing), there was a real risk of him losing that employment if the event of any interruption to his anti-psychotic medication and the development of a relapse.

48. The panel had previously found that "interruption" to his medication could be caused by the Appellant's non-compliance with the need to take any medication to which he had access (see [55]-[58], [72] and [74] of the decision); by his inability to access medication once the three months' supply physically provided to him by the SSHD had run out (see [59]-[60] and [73]); and/or by his inability to access appropriate 'first' and 'second' phase monitoring of his medication (see [64]-[67] and [75]).

49. Accordingly the panel clearly explained the requisite causal link between removal and destitution, irrespective of the SSHD's proposals to provide the Appellant with medication and funding for the first year. The panel's reasoning made clear that they did not consider that the risk of destitution was too remote or speculative.

50. Further, the panel was well aware that the SSHD's proposal to change the Appellant's medication from paliperidone administered by depot injections to risperidone in tablet form was to be affected at or about the point of removal

(see [11] above); and was concerned about the directly proximate consequences of that. The panel understood that there was an "inherent" risk of relapse in any such change in medication (see [65] of the decision) but the matters noted at [48] above all compounded that risk. In our assessment the panel was clearly concerned that the Appellant would relapse into psychosis and suffer the consequences of that, including destitution, in a period sufficiently proximate to the removal to meet the OA test.

51. In any event, as Mr Haywood highlighted, any error by the panel in this regard was not material in light of their other findings about the conditions were the Appellant to be hospitalised, and the risk of violence, that would breach Article 3 (see [28]-[37] above).

***Ground 3***

52. It is well established that the standard of proof requires the Appellant in a human rights claim to show a "reasonable likelihood" or "real risk" of Article 3 harm. The standard of proof may be a "relatively low one, but it is for the applicant to establish his claim to that standard": HKK (Article 3: burden/standard of proof), at [8]-[9], citing Kacaj (Article 3 – Standard of Proof – Non-State Actors) Albania* [2001] UKIAT 00018 at [12].

53. The SSHD argued that in this case the panel had wrongly reversed the burden of proof in two key respects.

54. First, Mr Holborn referred to that the panel's conclusion at [72] that there is "no reliable evidence to indicate how he would manage his drug regime". He contended that this finding illustrated that the panel had wrongly asked "Has the SSHD proved how the Appellant might manage his drug regime?" when the correct question should have been "Has the Appellant proved that he cannot manage his drug regime"? This much was clear from AM (Zimbabwe) at [33], where the Supreme Court held that it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it". He submitted that the panel's finding at [72] wrongly reversed the burden of proof in this regard.

55. We cannot accept this. The panel had directed itself at the outset that the Appellant bore the burden of proof: [8] of the decision. The panel made a positive finding that there was a real risk that the Appellant would forget to take his anti-psychotic medication. This was based on the Appellant's own evidence to this effect and medical records showing a history of poor compliance with oral anti-psychotic medication, even when in a controlled prison and hospital environment. It was also based on the fact that he was likely to be institutionalised, having been detained since 2011: [56]-[57], [72] and [74] of the decision. Some of the medical records had been disclosed by the SSHD but the Appellant was fully entitled to rely on them to discharge the burden of proof on this issue.

56. Mr Holborn also submitted that the panel had failed to take into account the fact that the Appellant has some insight into his illness and that he is prepared to take his medication, as confirmed by Dr Isherwood's evidence. We disagree. The panel was aware of these factors, but for the detailed reasons given, was not satisfied that the Appellant would consistently take his medication and/or be able to access it.

57. Further, Mr Holborn argued that the panel had erred in finding at [55] that the evidence of the Appellant's continuing forgetfulness in relation to his metformin tablets was "unchallenged" was incorrect: the Appellant had been cross-examined about how frequently he forgot to take this medication and explained that it was an occasional event, rather than a regular occurrence. However we agree with Mr Haywood that this is a flimsy basis for seeking to set aside the panel's clear other finding that he was not fully compliant when taking his oral anti-psychotic medication, even when detained: see [55] above.

58. For these reasons we do not consider that the panel erred with respect to the conclusion it reached at [72] by reversing the burden of proof or otherwise. Finally, as Mr Haywood rightly emphasised, any error by the panel on the issue of the Appellant's compliance with his medication regime was not material given that the panel found that there were other reasons why his access to medication could be interrupted: see [48] above.

59. Second, Mr Holborn pointed to the panel's finding at [88] that the SSHD had not made any inquiries in the Gambia into the circumstances of the Appellant's siblings. Again he contended that it was for the Appellant to prove his claim and it was he who was best placed to make contact and obtain evidence from (whether directly or by way of hearsay) his family members. He argued that the panel's finding indicated that it had reversed the burden of proof to the SSHD.

60. Again, we disagree. The panel gave careful consideration to the Appellant's own evidence about contact with his family and friends and made nuanced findings about the extent to which they would provide him with assistance if he returned to the Gambia: see [23]-[29], [31]-[32] and [81]-[83] of the decision. The panel simply "noted" at [30] and [80] that the SSHD had made no enquiries or her own about the Appellant's family, but we accept Mr Haywood's submission that the panel had not introduced any impermissible requirement for her to have done so. Further, the panel's observation to this effect at [88] was in the context of the Appellant having established a prima facie case that he would suffer a breach of Article 3, such that it was necessary for the SSHD to dispel the doubts about whether appropriate treatment could be obtained.

61. We therefore do not consider that the panel wrongly reversed the burden of proof on this issue either.

***Ground 4***

62. The SSHD contended that the panel had made a material error of fact in recording at [49] that the parties were agreed that the Appellant's anticipated

monthly medical expenses in the Gambia would total £55 which is equivalent to the figure relied on as the average monthly salary in the Gambia. The Appellant had not contended that his monthly medical costs would be this high. This was a material error because it underpinned the panel's finding that the medication would be unaffordable. This led to the panel's conclusion on the likelihood of relapse which in turn gave rise to their conclusion that there would be a breach of his Article 3 rights.

63. The panel did make an error in this regard. The average monthly wage in the Gambia is £55 but the medical costs were not that high. The panel had rightly recorded the costs at [49] as £14.90 per month for medication, plus £0.35/£3.00 per appointment with a medical professional (depending on whether at a public or private hospital).

64. However we accept Mr Haywood's submission that this error was not material in light of the other findings made by the panel as to why he might not access his medication, namely his own non-compliance and his difficulties in accessing a reliable source of medication, monitoring and supervision (as noted at [48] above). These findings do not focus on issues relating to cost.

**Conclusion**

65. In summary, therefore, we do not accept that the panel erred in any of the ways contended in the SSHD's first three grounds of appeal and we consider that the error disclosed by the fourth ground was not material to the outcome of the appeal. In respect of the first three grounds of appeal, we add this. The FtT is an expert tribunal charged with administering a complex area of law in challenging circumstances and it is probable that in applying the law in its specialised field the tribunal will have got it right. The decision of the FtT should be respected unless it is quite clear that it has misdirected itself in law: SSHD v AH (Sudan) [2007] UKHL 49; [2008] 1 AC 678. In this case, we were invited by the SSHD to find that a panel of the FtT misdirected itself in law notwithstanding the correct self-directions and references to salient authority on those very points of law. In each respect, the carefully reasoned decision demonstrates that the panel not only understood the law which it was to apply, but that it did so. The SSHD fails to establish any proper basis on which to interfere with the decision.

66. That being so, we emphasise and endorse what was said by the FtT at [89]-[90] of its decision. The Appellant will only be given a short period of Restricted Leave as a result of our decision. That is likely, in our experience, to be no more than six months. As the FtT noted in its concluding remarks, it is open to the SSDS during that time to address the basis upon which the appeal was allowed, whether by obtaining specific assurances from the Gambian authorities or otherwise. The SSHD is not obliged to permit the Appellant to remain indefinitely in the United Kingdom; she must only do so whilst it is clear, as it was to the FtT, that the measures she intended to put in place were insufficient to prevent a likely breach of Article 3.

**Notice of Decision**

67. The panel's decision did not involve any errors of law. The appeal is therefore dismissed.

**The Honourable Mrs Justice Hill DBE**

Sitting as a Judge of the Upper Tribunal
Immigration and Asylum Chamber

**12 September 2023**