



Upper Tribunal  
(Immigration and Asylum Chamber)

Appeal Number: DA/00646/2014

**THE IMMIGRATION ACTS**

Heard at Newport  
On 2 February 2016

Decision & Reasons Promulgated  
On 23 February 2016

Before

**UPPER TRIBUNAL JUDGE GRUBB**

Between

**THE SECRETARY OF STATE FOR THE HOME DEPARTMENT**

Appellant

and

**JK**

**(ANONYMITY DIRECTION MADE)**

Respondent

**Representation:**

For the Appellant: Mr I Richards, Home Office Presenting Officer

For the Respondent: Ms J Fisher instructed by Lawrence Lupin, Solicitors

**DETERMINATION AND REASONS**

1. Pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/2698) I make an anonymity order in the light of the respondent's personal circumstances and claim for asylum. Unless the Upper Tribunal or Court directs otherwise, no report of these proceedings shall directly or indirectly identify the Respondent (JK). This direction applies to both the appellant and to the respondent and a failure to comply with this direction could lead to Contempt of Court proceedings.

## **Introduction**

2. JK, whom I shall refer to hereafter as “the claimant”, is a citizen of Afghanistan. His age is uncertain but he has been treated throughout these proceedings as having come to the United Kingdom in August 2009 when he was 14 years of age. He claimed asylum on arrival on the basis that he feared being recruited by the Taliban and/or being persecuted by the Afghan authorities because they would impute to him his father’s political support for the Taliban and/or Hisbi-i-Islami. The claimant’s application for asylum was refused by the Secretary of State but he was granted discretionary leave until 8 February 2010.
3. Thereafter, the claimant made an in-time application for further leave to remain but that was again refused on 30 May 2012. He appealed to the First-tier Tribunal (“FtT”) but that appeal was dismissed on 21 September 2012. His subsequent appeal to the Upper Tribunal (“UT”) was successful and his case was remitted to the FtT. However, those proceedings came to an end when the Secretary of State withdrew the decision to refuse him leave to remain as a result of him becoming liable deportation.
4. The issue of his deportation arose because in August 2011, when the claimant was 16, he was involved in the London riots in Croydon. He effectively engaged in a number of acts of looting. On 10 January 2013, the claimant pleaded guilty at the Inner London Crown Court to 5 offences of violent disorder, handling stolen goods and a burglary. He was sentenced to a total of 28 months detention in a Young Offender’s Institution.
5. As a result of that conviction, the claimant was subject to the automatic deportation provisions of the UK Borders Act 2007 (the “2007 Act”). The claimant was notified that he was liable to deportation under those provisions on 29 January 2013. On 25 February 2013, the claimant’s legal representative made representations on his behalf that his deportation would breach the Refugee Convention and his rights under the European Convention on Human Rights, in particular Articles 3 and 8.
6. Following a screening and substantive interviews on 9 July 2013 and 27 August 2013 respectively, the Secretary of State refused the claimant’s asylum application and made the decision to deport him under the 2007 Act on 29 November 2013. The decision that the claimant did not fall within one of the exceptions in s.33 of the UK Borders Act 2007 gave the claimant a right of appeal to the First-tier Tribunal.

## **The Appeal to the FtT**

7. The claimant appealed to the First-tier Tribunal. In a determination dated 16 July 2014, the First-tier Tribunal (Judge Devittie and Ms M Padfield) allowed the claimant’s appeal under Articles 3 and 8 of the ECHR. The Tribunal accepted that the claimant’s account that he would be at risk from the Taliban (although not the Afghan authorities themselves) in his home area was well-founded and for a Convention reason. However, the Tribunal concluded that the claimant could safely and reasonably internally relocate of Kabul and so was not a refugee. However, the Tribunal allowed the appeal under Article 3 of the ECHR. The Tribunal found that there was a real risk that the claimant would commit suicide on return to

Afghanistan and, as a result, there were substantial grounds for believing that he faced a real risk of treatment contrary to Article 3.

### **The Appeal to the UT**

8. The Secretary of State sought permission to appeal to the Upper Tribunal against the First-tier Tribunal's finding that the claimant had established a breach of Article 3 (and probably Article 8) on the basis that there was a real risk that he would commit suicide if returned to Kabul.
9. The Secretary of State did not seek to overturn the First-tier Tribunal's finding that the claimant had a well-founded fear for a Convention reason in his home area. Instead, the Secretary of State argued that the First-tier Tribunal had erred in law in concluding that a breach of Article 3 had been established because it had failed to consider the background evidence concerning the availability of psychiatric services including the availability of medicines to treat his diagnosed psychiatric condition of PTSD and other mental health issues and the support the claimant would have from family in Kabul. The Tribunal's finding that the applicant would "not have the benefit of effective mental health strategies" was, as a consequence, flawed.
10. Permission was initially refused by the First-tier Tribunal but on 17 October 2014, I granted the Secretary of State permission to appeal on the basis that:
 

"It is arguable that the FtT failed to take into account evidence concerning the availability of treatment for the appellant's medical health in Kabul and that he would have family support there and gave inadequate reasons for concluding that there was a real risk he would commit suicide on return and during the removal process."
11. In his rule 24 Notice, the claimant sought to uphold the FtT's finding that, as a result of the real risk he would commit suicide on return to Afghanistan, the claimant had established a breach of Article 3.
12. In a decision dated 12 March 2015, the Upper Tribunal (Nicol J and UTJ Storey) set aside the First-tier Tribunal's decision in respect of Articles 3 and 8 based upon the risk to the claimant in Kabul of committing suicide. The UT agreed that the First-tier Tribunal had failed to take into account the presence of relatives of the claimant in Kabul and the availability of drugs which the claimant was presently being prescribed.
13. The Upper Tribunal, perhaps unsurprisingly given the parties respective positions, preserved the First-tier Tribunal's finding that the claimant had established a well-founded fear of persecution for a Convention reason in his home area. However, the Tribunal observed that the First-tier Tribunal's decision to dismiss his appeal on asylum grounds might have to be revisited if, in truth, his return to Kabul would breach Articles 3 or 8 of the ECHR because the finding that he could reasonably and safely internally relocate would not obviously have a sound basis.
14. The appeal was relisted before me for a resumed hearing in order to remake the decision under Articles 3 and 8 of the ECHR and, to the extent necessary, in relation to the claimant's refugee claim.

### **An Initial Matter**

15. Ms Fisher, who represented the claimant, raised with me at the outset of the hearing that I was the Judge who had granted the Secretary of State permission to appeal. She indicated that she did so as a matter of courtesy and was not inviting me to recuse myself.
16. I also had considered whether it was proper for me to hear the appeal given that I had granted permission to the Secretary of State earlier. As I have said, Ms Fisher did not seek to invite me to recuse myself and Mr Richards, who represented the Secretary of State, had no objection to my dealing with the appeal.
17. The common practice in the Upper Tribunal is that a Judge who deals with the error of law issue retains the appeal to remake it thereafter. It has never, to my knowledge, been suggested that a Judge is, in some way, disentitled to do so because he or she has been involved at that stage. The permission stage is, of course, an earlier stage in the proceedings when only an arguable view is taken on the legal merits of the appellant, here the Secretary of State's grounds of appeal. I do not see any basis upon which it can be said that a Judge dealing with the legal issues raised by an appeal to the UT cannot properly and fairly remake the decision except in wholly exceptional and unusual circumstances. I see no basis for recusing myself on the basis of there being any real possibility of bias applying the 'fair-minded and informed observer' test in Porter v Magill [2002] AC 357. In the light of that, I proceeded to hear the appeal.

### **The Evidence**

18. The claimant placed before the UT a very substantial bundle of documents, running to many hundreds of pages, some of which, but not all, were previously before the FtT. On behalf of the claimant, Ms Fisher sought permission to introduce a number of documents which were not considered by the First-tier Tribunal including additional objective evidence at pages 1-296 of the appeal bundle; an updated expert report from Dr Antonio Guistozzi dated 4 July 2015 at pages 10-21 of the appeal bundle; and an expert medical report from Dr Paul Foster, a Consultant Psychiatrist dated 1 February 2016 at pages 1-20 of an additional faxed bundle. Mr Richards did not object to the admission of any of this evidence and I granted permission to admit this evidence under rule 15(2A) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/2698 as amended).
19. The claimant relied directly upon a number of documents in appeal bundle in relation to the objective evidence in respect of Afghanistan. In particular, in her submissions Ms Fisher referred me to the *EASO Country Of Origin Report: Afghanistan Security Situation Update* (21 January 2016)(at pages 1-31 of Tab B). In addition the claimed relied upon two expert reports prepared by Dr Guistozzi dated 21 June 2014 (at pages 1-28 of Tab E) and 4 July 2014 (at pages 10-21 of Tab A); two supporting letters from Dr Juliet Cohen, a Forensic Physician dated 10 September 2012 and 15 October 2012 (at pages 110-111 and 107-109 respectively of Tab E); an expert medical report from Dr Paul Foster, a Consultant Psychiatrist (at pages 1-20 of a faxed supplementary bundle).

20. In addition, there was the evidence referred to by the First-tier Tribunal and also the claimant briefly gave oral evidence before me in relation to the issue of what, if any, relatives close or otherwise he had in Kabul.
21. Mr Richards only drew my attention to the background material in the Secretary of State's decision letter concerning psychiatric facilities and drugs available in Afghanistan. That material is helpfully set out on the second page of the Secretary of State's grounds seeking permission to appeal to the Upper Tribunal.

### **The Issues**

22. Ms Fisher submitted a detailed 19 page skeleton argument and I heard oral submissions from both Ms Fisher and Mr Richards. I am grateful to both representatives for their helpful and focussed submission on the live issues in the appeal.
23. Most of the factual issues in this appeal were not a matter of dispute. In particular, the claimant's past history in Afghanistan is accepted including that he would be at risk of persecution for a Convention reason in his home area. Further, Mr Richards did not seek to challenge the medical evidence concerning the claimant's underlying mental health problems. In particular, he did not seek to challenge the diagnosis set out in Dr Foster's very recent report that the claimant suffers from Post Traumatic Stress Disorder (PTSD) and Enduring Personality Change After Catastrophic Experience (EPCACE). Neither was it challenged that the claimant has a tragic and lengthy history of self harm and attempting suicide.
24. The central issue in dispute between the parties was, given the claimant's medical health problems, what were the consequences to him of removing him to Kabul? One disputed issue was the extent to which the claimant could, if at all, seek support from family members in Kabul. Mr Richards did not make any specific submission on the expert reports concerning the availability of psychiatric services or medication in Afghanistan. However, that remains an issue for me to resolve on the basis of the background evidence (which in part Mr Richards did rely upon) and the expert evidence. The issue then arises whether any support or medical services or drugs available would be such as to obviate the risk of the claimant self harming or attempting to commit suicide. If there was a real risk of that, despite any family support or, to put it in general terms, medical intervention Mr Richards did not make any submission that countered the claimant's case that his return to Afghanistan, in particular Kabul would breach Article 3 of the ECHR.
25. Ms Fisher in her submissions primarily focussed upon the Article 3 risk based upon the claimant establishing that there was a real risk that he would commit suicide in Afghanistan.
26. In addition, particularly in her skeleton argument, Ms Fisher also placed reliance upon Article 3 and the absence of adequate treatment such that the claimant fell within the exceptional circumstances contemplated in D v UK (1997) 24 EHRR 423. In that regard, she also relied upon Article 8.

27. As will become clear shortly, I am of the clear view that this appeal is resolved on the basis of Ms Fisher's primary submission based upon Article 3 and the risk to the claimant of attempting or committing suicide in Afghanistan. It is not, in the result, necessary therefore to consider in detail the claimant's Article 8 claim.

### The Law

28. Article 3 of the ECHR states that:
- "No-one shall be subjected to torture or to inhuman or degrading treatment or punishment."
29. The burden of proof is upon the claimant to establish that there are substantial grounds for believing that there is a real risk that he will be subject to treatment contrary to Article 3 on return to Kabul.
30. In the context of automatic deportation under the UK Borders Act 2007, his deportation would be unlawful if he can establish a breach of Article 3 as he would then fall within 'Exception 1' in s.33(2)(a) of that Act.
31. As regards the level of ill-treatment required to fall within Article 3, the consistent and unabated jurisprudence of the Strasbourg Court states that it must attain "a minimum level of severity" before a violation of Article 3 will be established (see, e.g. Ireland v UK (1978) 2 EHRR 25). The assessment of that minimum level of severity is relative which, in the words of the Strasbourg Court in, for example, A v UK (1998) 27 EHRR 611 at [20]:
- "Depends on all the circumstances of the case, such as the nature and the context of the treatment, its duration, its physical or mental effects and, in some instances the sex, age and state of health of the victim."
32. It was not suggested before me that serious incidents of self harm or attempted suicide would not reach the "minimum level of severity" as to engage Article 3. The crucial issue was whether a real risk of that consequence to the claimant had been established.
33. Recognising the fact that the consequence of suicide or attempted suicide fall potentially within Article 3, the Court of Appeal in J v SSHD [2005] EWCA Civ 629 set out the proper approach to applying Article 3 in this context. Dyson LJ (as he then was) set out six points at [26]-[31] as follows:
- "26 First, the test requires an assessment to be made of the severity of the treatment which it is said that the applicant would suffer if removed. This must attain a minimum level of severity. The court has said on a number of occasions that the assessment of its severity depends on all the circumstances of the case. But the ill-treatment must "necessarily be serious" such that it is "an affront to fundamental humanitarian principles to remove an individual to a country where he is at risk of serious ill-treatment" see Ullah paras [38-39].
- 27 Secondly, a causal link must be shown to exist between the act or threatened act of removal or expulsion and the inhuman treatment relied on as violating the applicant's article 3 rights. Thus in *Soering* at para [91], the court said:

“In so far as any liability under the Convention is or may be incurred, it is liability incurred by the extraditing Contracting State by reason of its having taken action which *has as a direct consequence the exposure of an individual to proscribed ill-treatment*” (emphasis added).

See also para [108] of *Vilvarajah* where the court said that the examination of the article 3 issue “must focus on the foreseeable consequences of the removal of the applicants to Sri Lanka....”

- 28 Thirdly, the context of a foreign case, the article 3 threshold is particularly high simply because it is a foreign case. And it is even higher where the alleged inhuman treatment is not the direct or indirect responsibility of the public authorities of the receiving state, but results from some naturally occurring illness, whether physical or mental. This is made in para [49] of *D* and para [40] of *Bensaid*.
- 29 Fourthly, an article 3 claim can in principle succeed in a suicide case (para [37] of *Bensaid*).
- 30 Fifthly, in deciding whether there is a real risk of a breach of article 3 in a suicide case, a question of importance is whether the applicant’s fear of ill-treatment in the receiving state upon which the risk of suicide is said to be based is objectively well-founded. If the fear is not well-founded, that will tend to weigh against there being a real risk that the removal will be in breach of article 3.
- 31 Sixthly, a further question of considerable relevance is whether the removing and/or the receiving state has effective mechanisms to reduce the risk of suicide. If there are effective mechanisms, that too will weigh heavily against an applicant’s claim that removal will violate his or her article 3 rights.”
34. That approach was subsequently approved by the Strasbourg Court in *Balogun v UK* (2013) 56 EHRR 3 at [31]-[34]. It has also been followed and applied in subsequent decisions of the Court of Appeal, for example, *AJ (Liberia) v SSHD* [2006] EWCA Civ 1736.
35. As Dyson LJ made clear in *I* (at [29]), an Article 3 claim may in principle succeed in a suicide case. However, it is necessary to establish that there is a real risk that the individual will commit suicide and that a causal link exists between the act of removal or expulsion and the violation of Article 3. There is a “high threshold” and it is relevant to consider whether the receiving state has “effective mechanisms to reduce the risk of suicide”.
36. It is accepted jurisprudence both in Strasbourg and domestically that the ‘high threshold’ recognised in cases such as *D v UK* (1997) 24 EHRR 423 and *N v SSHD* [2005] UKHL 31 and *N v UK* (2008) 47 EHRR 39 applies in cases of this nature where the individual’s claim arises from a ‘naturally occurring illness’ rather than as a result of a deliberate act by the State or third parties (see, e.g., *I* at [28]; *AJ (Liberia)* at [12]-[14]; *Balogun* at 31)).
37. There is support for the view in Strasbourg that the ‘high threshold’ test may require some modification, at least in its application, where the circumstances befalling an

individual arise from ‘natural causes’ which are the product of state or third party actions, for example, appalling social and living conditions produced by civil war (see Sufi and Elmi v UK (2012) 54 EHRR 9).

38. The point was picked up by the UT in GS and EO (Article 3 – Health Cases) India [2012] UKUT 00397 (IAC) at [85(9)] where the UT suggested that in cases involving the risk of suicide the approach of the law may need some modification in its application because:

“The removal of the individual creates or enhances the risk of suicide and so they are not concerned solely with a natural underlying disease or illness which, although treatable in the UK would not be treated in the individual’s home country.”

39. It will be relevant whether the risk of suicide of self harm can be said to be the product of the ill-treatment meted out by the receiving state or solely as a result of a naturally occurring mental illness (see, Y and Z (Sri Lanka) v SSHD [2010] INLR 178).
40. Whilst I accept in the light of the jurisprudence that a ‘high threshold’ must be met in suicide cases, that approach must be applied in context. In my judgement, the ‘enhancement’ of the risk of suicide, a consequence of the individual removal by the Secretary of State is an important aspect of the decisional matrix not least in establishing a causal link between the risk and the act or threatened act of removal or expulsion (see, I at [27]). I accept, however, that a “high” threshold is imposed by the law in order to establish, in effect, a real and imminent risk of treatment of such severity as to engage Article 3.
41. With that legal structure in mind, I now turn to make my findings in the light of all the evidence.

### Findings

42. As I have said, the primary facts were not (with the exception of what family support he had in Kabul) disputed by Mr Richards on behalf of the Secretary of State. Likewise, Mr Richards did not seek to challenge the experts view on the claimant’s mental health; the availability of psychiatric treatment or drugs for the claimant in Afghanistan or that he would be at increased risk of self-harm and suicide if deported. However, despite that essential agreement, it is important that I set out the experts views that I have found persuasive and which leads me to my ultimate finding in respect of Article 3.
43. The claimant was born on 8 August 1993 and so is now 22 years of age. He came to the UK in August 2009 when he was 16 years old.
44. The claimant’s mental health is dealt with in a number of reports including that of a prison psychiatrist dated 15 December 2013, Professor Katona’s report of 25 November 2013, Dr Cohen’s two letters dated 10 September 2012 and 15 October 2012 and most recently in the report of Dr Foster dated 1 February 2016. The claimant’s underlying mental health condition was not disputed by Mr Richards. I set out in some detail the report of Dr Foster which is very recent indeed and, in my judgment, is highly persuasive and I accept it.



45. In his report, Dr Foster identified that the claimant suffers from PTSD and EPCACE. Dr Foster says this at paras 35-38 of his report (noting that here are 2 paragraphs each numbered 37 and 38 in the original):

“35. In my clinical opinion [the claimant] fulfils the criteria for the diagnosis of Post-traumatic Stress Disorder ICD10 F43.1.

- (a) There are a number of significant stressful events and situations before [the claimant] arrived in the UK which were exceptionally threatening or catastrophic in nature and likely to cause pervasive distress in any individual.

These would include witnessing fighting, injuries and death prior to the defeat of the Taliban in Afghanistan, aggressive treatment by the Iranian authorities whilst he was residing there when he was reportedly kicked, punched, slapped and told he would be deported. On his return to Afghanistan from Iran he was reportedly attacked by the Taliban who beat him and broke his arm and one of his teeth. He learnt that his father had been killed and his older brother was forced to join the Taliban. He then learnt that brother too had been killed and the Taliban demanded that [the claimant] join them to replace his brother.

- (b) There is evidence of persistent remembering or ‘reliving’ the stress or by intrusive flashbacks, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor as indicated in mental state examination findings.
- (c) Actual or preferred avoidance of circumstances resembling or associated with the stressor. As indicated [the claimant] avoids watching TV and on occasions leaving his home as he is fearful that he would witness an incident which would trigger a traumatic memory.
- (d) He demonstrates symptoms of increased physiological arousal shown by difficulty in falling asleep, irritability and outbursts or anger, and difficulty concentrating. These were evident as outlined in mental state examination. His impairment in concentrating and his irritability was apparent in terms of his agitation at interview and his difficulty waiting to be interviewed and frequent wish to end the interview.

36. In addition to this diagnosis the current ICD-10 includes a diagnosis of Enduring Personality Change After Catastrophic Experience (EPCACE) in the Disorders of adult personality and behaviour section. Code ICD 10 F62.0.

“Enduring personality change may follow the experience of catastrophic stress. The stress must be so extreme that it is unnecessary to consider personal vulnerability in order to explain its profound effect on the personality. Examples include torture, and prolonged exposure to life-threatening circumstances. Post-traumatic stress disorder (F43.1) may precede this type of personality change, which may then be seen as a chronic, irreversible sequel of stress disorder. In ICD-10 Diagnostic guidelines the personality change should be enduring and manifest as inflexible and maladaptive features leading to an impairment in interpersonal, social, and occupational functioning. In order to make the diagnosis, it is essential to establish the presence of features not previously seen, such as: a hostile or mistrustful attitude towards the world; social withdrawal; feelings of emptiness or hopelessness; a chronic feeling of being “on edge”. The personality change must have been present for at least 2 years, and not be attributed to a pre-existing personality disorder or to a mental disorder other than post-traumatic stress disorder (F43.1.)

37. The finding of personality disorder in the prison records does not therefore imply that [the claimant] is not suffering from complex PTSD as the two conditions can be considered to be overlapping in terms of their aetiology and presentation.
37. In my view {the claimant} does demonstrate a mistrustful attitude toward the world, social withdrawal and feelings of hopelessness together with chronic feeling of being ‘on edge’ all of which were apparent at interview and from previous accounts in the other psychiatric reports have been present for at least 2 years.
38. I agree with Professor Katona’s comment that [the claimant’s] PTSD are not likely to have been primarily caused by separation from his family and native country or by his being stabbed in the UK an incident which post-dates the onset of his mental health problems. I also agree with Professor Katona that his affective symptoms of depression and anxiety and his abnormal auditory experiences i.e. voices, which I would categorise as pseudo-hallucinations are best understood as part of complex post traumatic stress disorder which, as he stated, can also manifest with psychotic symptoms.
39. Personality Change After Catastrophic Experience ICD 10 F62.0 is regarded as the most appropriate description for Complex PTSD in ICD classification. This condition is most likely to occur when there is interpersonal trauma which is prolonged and occurs in childhood or adolescence. [The claimant] experienced these traumatic experiences prior to arriving in UK at the age of 14 years. The nature

of the trauma he experienced was largely interpersonal and it was prolonged for much of his childhood. I am therefore in agreement with Professor Katona that he is suffering with complex PTSD.”

46. The medical and other evidence demonstrates that the claimant’s mental health has resulted in several interventions as a result of a number of instances of self harm including attempted suicide. The claimant was, at one point, subject to compulsory detention under the mental health legislation between 9 September 2010 and 16 October 2010. Dr Foster states at para 39 that, having considered whether the claimant is “feigning or exaggerating” his symptoms:

“I do not find any evidence for this and, in my view, his clinical presentation is in keeping with his reported experience of severe trauma.”

47. Dr Foster’s views are supported by both Professor Katona and Dr Cohen.
48. In respect of the effect upon the claimant of returning to Afghanistan, Dr Foster deals with this at paras 45-51 of his report. He says this:

“45. I understand from the country expert report that {the claimant’s} living conditions if he were residing in Kabul would be limited. Although his relatives may provide some accommodation it is stated that it is likely he would be expected to move out after a period. The rising unemployment in the area is reportedly driving many young men into crime. It was apparent from my interview with [the claimant] that he is easily influenced and led by others and he cited this as one factor resulting in him taking part in the London riots. He is likely to be particularly vulnerable to be led into crime in his situation in Afghanistan.

46. Others factors that make this more likely are his impaired cognitive function, his continued use of substances and alcohol in potentially damaging ways, and the manner in which he cuts off from his feeling i.e. dissociation. All these factors are likely to combine and would mitigate him seeking and accepting ongoing help fro his mental health problems.
47. The country expert report highlights the paucity of mental health services in Afghanistan, with only 6 psychiatrists employed. There is no system of primary and secondary care health services of the kind provided in the UK making it practically difficult for him to access help. Furthermore it is unlikely that there is the level of psychological expertise to deliver the kind of specialist evidence based psychological treatment that he requires for his mental health difficulties, which as indicated may need to be continued for some two years. In addition I would agree with Professor Katona’s comment that [the claimant’s] at times disturbed and unpredictable behaviour would make him more vulnerable to being stigmatised and treated in a potentially inhumane way.

48. [The claimant] told me that he had been offered psychological treatment whilst residing in Swansea. He could give me no details of this and I have no independent corroboration of it. However he told me that he had not been able to get to the appointments because of his sleep disturbance and at times his anxiety about leaving his home.
  49. There are also further concerns about the safety of [the claimant] returning to Afghanistan of a general nature related to the violence and unrest in the country outlined in the country expert report which would impact on his mental health. I am not able to comment on the general risks to his safety in Afghanistan.
  50. With regard to whether the presence of family members in Afghanistan would make a material difference to his mental health problems, it is difficult to be certain. Whilst his relatives may offer him accommodation and support, he appears to regard his main source of support and his home to be in the UK.
  51. Regarding [the claimant's] risk of suicide if he were removed to Afghanistan, in my view this would be increased. He has a long history of self harm which has persisted since his arrival in the UK. He uses this as a maladaptive coping mechanism. It is very likely that he would continue to self harm at probably increased frequency and severity in Afghanistan because of the stresses associated with his residing there as outlined above. His self harm attempts have been on occasions severe including putting ligatures around his neck, putting a bag over his head and cutting his neck. It appears likely, as Professor Katona stated, that some of his violence to himself is motivated by his wish to die; in addition his serious self harm attempts even if done with the purpose of soothing his emotional state could accidentally result in his death. [The claimant] also told me there would be no life for him if he had to return to Afghanistan and that he would end his life using a knife or gun or jump from a high building."
49. Dr Foster's opinion that the claimant would be at an increased risk of suicide if removed to Afghanistan is supported by Professor Katona in his report at para 10 where he states:
- "(e) Though his self harming is impulsive and usually non life-threatening, [the claimant] sometimes experienced a real wish to die as well as a wish to use pain to distract from his mental symptoms. Suicidality is increased in people with PTSD ... In the light of this I think that there is high risk that [the claimant] would attempt suicide (with potentially fatal results) if he lost hope of remaining in the UK. In my opinion the risk would be very significant in the UK prior to removal and would remain so during the removal process and once he was back in Afghanistan."

50. The medical experts clearly link the claimant's risk of suicide and self harm to his underlying mental health pathology of PTSD and EPCACE which are, themselves, the result of the claimant's adverse experiences in Afghanistan.

51. In his report, Dr Foster deals with the claimant's future treatment and prognosis at paras 40-44 as follows:

"40. NICE 2005 recommends psychological treatments as first line and medication second line treatment in PTSD. The psychological treatments with the best evidence base are eye movement desensitisation and reprocessing (EMDR) and trauma-focused cognitive behaviour therapy. In the case of complex PTSD the length of treatment is greater and particular skills and experience are required for this therapy.

41. The ISTSS expert consensus treatment guidelines for complex PTSD in adults Nov 5 2011 state 'The treatment for Complex PTSD, then, emphasises not only the reduction of psychiatric symptoms, but equally, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources.'

42. The recommended treatment model involves three stages of phases of treatment, each with a distinct function. This protocol is supported by evidence from two randomised controlled trial studies.

Phase 1 focuses on ensuring the individual's safety, reducing symptoms, and increasing important emotional, social and psychological competencies. Phase 2 focuses on processing the unresolved aspects of the individual's memories of traumatic experiences. Phase 3, involves consolidation of treatment gains to facilitate the transition from the end of the treatment to greater engagement in relationships, work or education, the community life.

Studies suggest that therapies which include both stabilisation/skills building and memory processing generally appear superior to those which include only the stabilisation component.

The first goal in phase 1 is to ensure that the priority of any mental health treatment, patient safety, has been achieved. A second goal is to strengthen the individual's capacities for emotional awareness and expression, increase positive self- concept and address feelings of guilt and shame, and increase interpersonal and social competencies. The Phase 1 goal of achieving patient safety entails reducing patient or environmental characteristics that make the patient a danger to him/herself or others. This often requires reduction of symptom acuity (e.g. through the use of medication) and improvement in basic self-management skills.

The majority of experts consider 6 months a reasonable length of time for Phase 1, and 3 - 6 months for Phase 2. Phase 3 was pre-defined in the survey as a 6-12 month interval during which

symptoms were in emission and consolidation took place. Thus this protocol requires up to 2 years of specialist treatment.

43. With regard to his psychotropic medication treatment which is presently the antidepressant Mirtazapine 45 mg and the antipsychotic Chlorpromazine 25 mg twice daily, I agree with Professor Katona that these medications should be reviewed by a Consultant psychiatrist as there may be better medications for control of his symptoms, and Chlorpromazine is now rarely used as a medication to control psychotic symptoms. In addition his voices are only partially controlled by his present regime.
44. I agree with Professor Katona that [the claimant's] case is complex and he would be best treated by a specialist trauma-focused Psychotherapy Service. The early onset of his trauma and his limited cognitive functioning on mini-mental state examination are poor prognostic factors."
52. Dr Foster's report is clear and unequivocal: the claimant's mental health problems are complex and deep rooted. Treatment is complex and requires more than simply the prescription of anti-depressants. A sophisticated therapeutic regime is called for straying way outside that basis therapeutic response to the claimant's mental health problems. That regime involves placing the claimant in a safe and supportive environment. That is important to bear in mind when considering what effective mechanisms there are in Kabul for dealing with the claimant's mental health needs.
53. What, if any, factors or 'effective mental health strategies' are likely to be in place in Afghanistan to prevent the claimant from, as the evidence above clearly leads me to conclude, of being at an increased and real risk of committing suicide?
54. Mr Richards relied upon the availability of two drugs which the claimant currently takes namely Mirtazapine and Chlorpromazine. These are conventional anti-depressant and anti-psychotic prescription drugs. Mr Richards submitted that the evidence dating back to 2013 as set out in the refusal letter (which is summarised in the Secretary of State's grounds of appeal to the Upper Tribunal) demonstrates the availability of this medication. That evidence has, however, to be set against the expert evidence both from Dr Foster and Professor Katona but also the non-medical evidence from Dr Giustozzi in his two reports.
55. Dr Foster's report makes plain that the anti-depressant and anti-psychotropic medication which may be available is not, in itself, an adequate treatment for the claimant's complex PTSD which requires a three stage or phase treatment approach. First, there is a need to reduce the claimant's symptoms and emotional, social and psychological competencies. Secondly, focus upon the unresolved aspects of his memories of traumatic experiences and thirdly a transition from treatment to greater engagement in relationships, work or education and community life (see para 42 of his report). In my judgement, the availability of medication in itself is far from a satisfactory treatment regime for the claimant's underlying conditions which create the increased risk of suicide. In my judgement, that treatment requires a relatively sophisticated mental health treatment regime in a climate of relative stability.

56. The evidence of Dr Giustozzi, in particular, tells heavily against such a regime being available to the claimant in Kabul. In his earlier report dated 21 June 2014, Dr Giustozzi sets out the position as follows at paras 21-28 of his report:

“21. In Afghanistan [the claimant] would not receive a level of mental health care even remotely comparable to that he could receive in the UK. Outside a few cities (see below), the provision of mental health care in Afghanistan is almost non-existent. The country’s only mental health hospital (Kabul) is in bad condition due to war damage and lack of maintenance. Furthermore, it lacks equipment. The hospital has 60 beds (2011). In 2003 some patients were reported to be permanently chained to the beds, while violent and schizophrenic patients were confined to darkened cells. Plans to expand facilities with the building of new hospitals were never implemented. There is a problem of understaffing, as many of the already limited number of trained mental health professional have left the country. In 2010 there were only two fully trained psychiatrists in the whole of Afghanistan, a few psychiatric nurses and not even one psychologist; 40 more psychiatrists and psychologists had received partial training. In early 2010 the National Health Strategy was revised to give more space to mental health care, the focus being on training health staff in mental health care awareness and in forming psychosocial counsellors. However, the limited training imparted in mental health care is resulting in the abuse of psychotropic drugs, with an estimated 30% of the population taking such drugs and abusing them (see below).

22. If we consider that according to the World Health Organisation as of 2010 about 60% of Afghans suffer from various forms of mental health problems, it is obvious that the chances of having access to care for the average Afghan patient with mental health conditions are slim indeed. The opportunities for psychosocial support are almost non-existent in Afghanistan, mainly because of the extreme shortage of trained mental health professionals. Although the government had made mental health one of the priorities in the reconstruction of the health system, in practice little was done, not even in terms of starting training programs for mental health specialists. This situation led a doctor to define the mental health care system of Afghanistan as ‘almost nonexistent’ during a briefing to the Congress of the United States. In early 2014 the International Medical Corps commented:

‘National guidelines recommend the inclusion of mental health services in the Basic Package of Health Services (BPHS) with linkages to other services provided under the Essential Package of Hospital Services (EPHS). However, implementation is inconsistent and fragmented and reliable results are still unknown. At the tertiary level,

national guidelines do not currently exist to streamline or improve the overall staff capacity, quality control measures, or budgetary resources at the mental health and detoxification institutions in Kabul.'

The European Union is supporting the rehabilitation of the mental health hospital and has paid for the construction of a new building within it; the capacity of the hospital remains rated at 60 beds, however. Counselling is available in small clinics thinly distributed around the country. Even in Kabul they have few and far between and attending them could seriously disrupt attending school or presence at the job place. A report by the umbrella organisation of NGOs operating in Afghanistan dated 2008 stated that

'NGOs commented that healthcare professionals do not receive enough training or funding to train others. NGOs specified mental health and disability as an area extremely lacking of educated and qualified staff with capacity to address these conditions and severely inadequate monetary support as well.'

23. Some international NGOs offered training and help to the Afghan mental health service; of all the NGOs listed as active in Afghanistan, only two appear to be active in mental health care. Greek NGO Klimaka for example provided some equipment, translating a training manual into local languages, renovated facilities and provided 8 week training courses. HealthNet TPO is the largest NGO involved in mental health care in Afghanistan, but the impact has so far been limited; their main contribution is the supply of some medicines. According to a WHO report,

'Psychosocial interventions centres were established in 2005 by some international NGOs in the capital but they have not been implemented in rural areas.'

24. In recent years a number of psychotropic drugs have become available in Afghanistan, usually imported from Pakistan and mostly illegally (80%). In fact the country now suffers from widespread abuse of tranquillisers, including the more powerful ones. The import of tranquillisers is driven by drug addiction, not by prescription or hospital use. To the extent that they are available, patients have to pay for them. The mental health hospital in Kabul only receives \$100 worth of medicines monthly for 2,500 patients. According to the WHO,

'100,000 US \$ was directed towards mental health in 2004. Of all the expenditures spent on mental health 50,000 US \$ is directed towards mental hospitals. The percentage of the population with free access to essential psychotropic medicines is less than 1% For those that pay out of pocket, the cost of antipsychotic medication is 6 Afghani (12% of



daily minimum wage) and antidepressant medication is 8 Afghanis (16% of daily minimum wage). Mental disorders are not covered by social insurance schemes.'

25. There is no proper supervision of the distribution of medicines in Afghanistan. 80 poorly paid inspectors from the Ministry of Public Health are not even able to ensure that Pharmacies are staffed by at least one pharmacist as required by the law. Two distribution channels exist, one being International NGOs (such as the Swedish Committee for Afghanistan, SCA), which deals with basic medicines only, and the other being small importers who operate without licence or authorisation and mainly buy drugs in Pakistan and re-sell them in Afghanistan. Such drugs are transported in common lorries without refrigeration or any other particular care, which can lead sometimes to the deterioration of the medicines, without patients and medical personnel being aware of that. It is impossible to establish exactly which drugs are imported through the second channel, but in general these too appear to be widely requested products, rather than specialist medicines, not least because obtaining such medicines in Pakistan might be difficult and/or expensive, while the possibility of selling them would remain uncertain. Afghan doctors have little or no access to up-to-date information about the availability of new and specialist drugs and therefore tend not to prescribe them, removing any incentive for importers to seek the products in Pakistan.
26. There is no 24 hour supervised care hostel for patients suffering from mental health problems in Afghanistan. All that is available apart from the mental health hospital in Kabul mentioned above is counselling for PTSD with 16 'psycho-social centres' spread around the Afghan cities of Kabul and Herat, which essentially provide counselling to individuals suffering from mental health problems, mostly PTSD and depression. These are manned by nurses and doctors who have been partially retained to deal with mental health issues, rather than by mental health specialists. Given the very widespread incidence of PTSD in Afghanistan (a 2002 survey by the U.S. Centers for Disease Control and Prevention found that 42 percent of Afghans suffered from post-traumatic stress disorder), even for this type of patients receiving consistent support is very difficult. It is not known whether psychological treatments such as 'eye movement desensitisation and reprocessing' (EMDR) and trauma-focused cognitive behavioural therapy' are available in Afghanistan; they certainly would not be available outside the only mental health hospital existing in the country.
27. Individuals will be considered by the Afghan health service for mental health care assistance if they present themselves to a clinic or hospital of their own will or are brought there by their relatives.

Then a doctor will assess them and decide whether they are entitled to assistance. It will not be the case, therefore, of the health service proactively reaching out to [the claimant]. His needs will be assessed against those of the large number of people who suffer from mental health condition (approx. 2 million in Kabul, but of course not all seeking medical support). It is unlikely that he would then receive more than cursory attention by the medical staff at the country's only mental health hospital.

28. Several antidepressants are available in Afghanistan as authorised drugs, according to the latest (2007) National Licensed Drug list. However, the real issue is that in practice having access to treatment will be extremely difficult: [the claimant] will have to reside in a city to have access, with only Kabul offering a relatively wide range of treatment opportunities in the only mental health hospital in the country. In Kabul he would have to compete with a large portion of the five million residents of the city (40% suffering mental health issues, but unknown numbers effectively reporting to the health system) for the attention of a handful of mental health staff (see above for the numbers). Even these very limited opportunities for treatment will only be available in Kabul, but it is far from certain that [the claimant] will be able to live in Kabul, given the high cost of living there and his likely inability to get a well paid job given his condition."

57. In his more recent report dated 4 July 2015 Dr Guistozzi updates the position at para 8 of his report as follows:

"8. As mentioned in my previous report, several psychotropic medications are available in Afghanistan, even if not all those that are available on the UK market. Mirtazapine and Chlorprozamine are both licensed for distribution in Afghanistan. There are issues with the quality of medicines, due to the presence of counterfeits manufactured in Pakistan; it is estimated that up to half of all medicines circulating in Afghanistan are Pakistani counterfeits. There has been no significant expansion or improvement in the provision of mental health facilities in Afghanistan compared to what I detailed in my previous report. The mental health hospital still has only 60 places, although the number of psychiatrists operating there has gone up to 6 (from 2 in 2010). There are also about 30 other doctors, who have received some training in mental health care without being fully qualified psychiatrists. It should be noted that to be admitted to this hospital, it is necessary to be accompanied by a relative all the time."

58. As I have said early, none of this evidence was challenged by Mr Richards. The availability of treatment for mental health is bleak in Afghanistan even though some provision is made in Kabul. Drugs may, however, be black-market counterfeits. Secondary psychiatric care is sparse in the extreme. There are only 60 hospital places

and 6 practising psychiatrists in the whole of Afghanistan. Dr Guistozzi also makes the point that admission to hospital requires a relative to accompany the individual. For the reasons I give below, I am satisfied that it is unlikely that the claimant will have the familial support (beyond possibly the short-term) that would allow him to access any needed hospital treatment. Consequently, in my judgment there is

59. The dismal position that the claimant would face, as regards treatment and professional support in Kabul, does not in my judgement obviate the real risk that he will attempt or succeed in committing suicide on return. There is very likelihood that he would not be able to access effective treatment or medication. There is no evidence, to which my attention was drawn, that suggests the sophisticated regime he requires for his complex PTSD is available in Afghanistan. The parlous situation recognised in the reports and background material can provide no confidence that it is.
60. The claimant does, of course, have a well-founded fear of persecution in his home area. That subjective (and objective) fear taken together with the evidence which, I accept, demonstrates that he will be a vulnerable individual in Kabul creates the very milieu of instability and social and other support which is essential to the treatment that the experts, in particular Dr Foster, indicate is vital to the claimant's wellbeing and road to recovery from his underlying mental health pathology. In my judgement, that will simply be absent if he returns to Kabul.
61. The Secretary of State relies upon the fact that the claimant has family in Kabul to support him. In his evidence, the claimant accepted that he had family on his mother's side in Kabul whom he visited when he was young but they were not close. In his evidence before me, it was clear that this family was related to his mother and had been visited by his cousin (from the UK) to obtain documents which had been left there by his maternal uncle. The claimant maintains that he is unaware where his close family are. I bear in mind that the Red Cross have been unable to trace the claimant's close family.
62. The claimant gave his oral evidence in a clear and open manner and I accept what he told me. It is unclear to me why the First-tier Tribunal found, on evidence very similar to that which I heard, that he had "very close" relatives in Kabul. He clearly does not have close family in Kabul. Likewise, I am satisfied that there is no realistic prospect that his close family could be traced and could come to support him in Kabul if he lived there. I accept that he may (and I put in no higher than that) be able to obtain some short-term support from the family that he does have in Kabul but there is no reason to believe that that support would be long term. The family are not close and the claimant has little knowledge of them or they of him. The claimant's social and medical needs are not short term.
63. In any event, in the absence of the necessary professional support - which I find there is a real risk the claimant will not be able to obtain in Kabul - the fact that he may obtain some support (including perhaps accommodation) in the short term with his relatives but whom he barely knows, will not provide a social structure that will materially assist in removing the increased risk of suicide which, on the basis of the expert evidence, I find will exist if the claimant returns to Kabul.

64. I do not propose to set out in any detail the background evidence concerning the situation in Afghanistan, in particular in Kabul. I was only fleetingly referred to it by Ms Fisher. In AK (Article 15(c)) Afghanistan CG [2012] UKUT 00163 (IAC), the UT noted the possibility of internal relocation to Kabul (where the circumstances were not such that Art 15(c) of the Qualification Directive was generally engaged) but that the issues of “safety” and “reasonableness” were fact-sensitive. That case dealt with background material up to early 2012. The *COI Report, Afghanistan* (August 2015) (at Tab B, p71-92) acknowledges that the “humanitarian situation” in Afghanistan has deteriorated although not to the extent to engage Art 15(c) of the Qualification Directive (see para 2.4.4). The vulnerability of the individual is a factor to be considered. Suffice it to say, Kabul remains a dangerous place (see *COI Report, Afghanistan*) (August 2015) at para 4.4. Dr Guistozzi, in his reports, highlights the difficulties that the claimant would face in obtaining employment or other social support in Kabul (see in particular paras 31-32 of his report dated 21 June 2014). Dr Guistozzi also (at para 30 of that report) highlights the negative attitude towards individuals suffering from mental illness as follows:

“30. There is little understanding among the wider public and law enforcement agencies about mental illness. The dominant attitude towards mental health conditions remains based on prejudice. It is still common to think, for example, that epileptic people are possessed by djinns or spirits, particularly among rural folk or recent immigrants to the cities. Individuals with symptoms of mental illness are therefore likely to suffer discrimination and face increased difficulties obtaining accommodation, employment and jobs in a new area. An attempted suicide could also lead to internment and/or discrimination as suicide is look upon very negatively in all Muslim countries. If health staff are unable to deal with schizophrenia and other serious mental health conditions adequately; one can imagine how the average man in the street will deal with it.”

65. Although Ms Fisher did not resile from the argument that the risk of suicide by the claimant was not restricted to his circumstances when in Afghanistan, she relied principally upon that rather than any risk before or during the process of removal itself. She was right to do so. The evidence does not establish that risk engaging Art 3 prior to the claimant actually returning to Afghanistan. I accept that the UK government is likely to put in place mechanisms to prevent the claimant committing or attempting to commit suicide in the UK and prior to arrival in Kabul.

66. Based upon the evidence, I am however satisfied that there is an increased and real risk to the claimant of committing or attempting to commit suicide on return to Kabul despite the potential availability of any medication (which is practically doubtful) and despite the short term availability of some family to provide support in Kabul. The claimant has a long history of self harm and attempted suicide. He has attempted suicide many times. His underlying mental health pathology is established and is not in dispute. Also established are the therapeutic needs for the treatment of his complex PTSD which is the root cause of the risk to him taken with his past experiences and the well-founded fear he has on return to Afghanistan.

Equally, his vulnerability on return is established as is the lack of social and other stability required for an effective mental health treatment strategy which itself is not likely to be available to him on return to Kabul given the parlous state of mental health facilities and treatment in Afghanistan including Kabul.

67. Applying the approach set out in I set out above at para 33, I am satisfied that there is an increased and real risk to the claimant that he will self-harm or attempt suicide if he is removed to Afghanistan which will be causally linked to the act of removal. There would not be in place effective mental health strategies or familial support which would obviate that risk. Applying the "high threshold" requirement, this is a case where the underlying causes of the claimant's mental health problems derive from his past history and his removal by the UK to Afghanistan. That is a relevant factor which will exasperate his very real mental health problems. There are, in my judgment, analogues with the Court of Appeal's approach to the individuals' circumstances in Y and Z (Sri Lanka) where the individuals inability to seek the required treatment was born of the very objective fear in Sri Lanka that gave rise to their mental health problems and the risk of suicide (see *per* Sedley LJ at [61]). In this case the claimant will also be returned to the place which is the source of his mental health problems and where he has an objective well-founded fear (at least in his home area) and for which no effective treatment or effective familial support will be available in order to obviate that risk.
68. On the basis of the evidence, I am confident those circumstances create a real risk that he will attempt suicide. I am satisfied that the 'high threshold' is met in that the claimant's circumstances will degenerate on return in the absence of adequate medical and other support to a level which entails a severe loss of dignity and humiliation leaving him exposed to the real risk of harming himself including fatally. That decline into a state of self-harm and suicidal propensity cannot, in my judgment, be seen as other than calling out for the 'humanitarian' response through the application of Art 3 as presaged by the Strasbourg and domestic case law.
69. For these reasons, there are substantial grounds for believing that if he is returned to Afghanistan (Kabul) he faces a real risk of inhuman or degrading treatment as the consequences to him of attempting suicide reach minimum level of severity to engage Article 3 of the ECHR.
70. For these reasons, I am satisfied that the claimant's deportation to Afghanistan (in particular to Kabul) would breach Article 3 of the ECHR and would, therefore, be unlawful under s.33 of the 2007 Act.
71. Mr Richards accepted that if that was my finding, the claimant was also a refugee as he had a well-founded fear of persecution in his own area (as found by the First-tier Tribunal) and he could not safely and reasonably internally relocate to Kabul. For that reason also, he accepted, that the claimant's deportation would be unlawful under s.33 of the 2007 Act as it would breach the Refugee Convention.
72. In the light of my finding in respect of the Refugee Convention and Article 3, no separate issue arises in respect of Art 8.

**Decision**

73. For the reasons given by the Upper Tribunal in its decision dated 12 March 2015, the decision of the First-tier Tribunal to allow the claimant's appeal involved the making of an error of law and that decision has been set aside.
74. For the reasons I have given above, I remake the decision allowing the claimant's appeal against his deportation pursuant to the automatic deportation provisions in the 2007 Act on the basis that his deportation would breach Article 3 of the ECHR and also the Refugee Convention.

Signed

A Grubb  
Judge of the Upper Tribunal

Date: