



Upper Tribunal
(Immigration and Asylum Chamber)

IA/12139/2012

THE IMMIGRATION ACTS

Heard at Field House
On Thursday, 28 August 2019 and
Tuesday, 10 September 2019

Decision & Reasons Promulgated
On Wednesday, 13 November 2019

Before

UPPER TRIBUNAL JUDGE DAWSON
DEPUTY UPPER TRIBUNAL JUDGE SUTHERLAND WILLIAMS

Between

GM
[ANONYMITY DIRECTION MADE]

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr A Eaton, Counsel, instructed Duncan Lewis Solicitors
For the Respondent: Mr S Kotas, Senior Home Office Presenting Officer

Anonymity

Rule 14: The Tribunal Procedure (Upper Tribunal) Rules 2008

Anonymity was granted at an earlier stage of the proceedings. It is appropriate to continue the order. Unless and until a tribunal or court directs otherwise, the appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him or any member of his family. This direction applies both to the appellant and to the respondent. Failure to comply with this direction could lead to contempt of court proceedings.

DECISION AND REASONS

Introduction

1. This is an appeal that has, on any view, a lengthy history.
2. The appellant, an Indian citizen, entered the United Kingdom on 9 September 2010 on a tier 4 general student visa. In November 2010, not long after his arrival, he was diagnosed with kidney failure.
3. In November 2011, citing his medical condition, the appellant applied for leave to remain. That application was refused by the respondent on 8 May 2012.
4. The appellant thereafter appealed under section 82 of the Nationality, Immigration and Asylum Act 2002 to the First-tier Tribunal. By the time of his hearing on 9 July 2012, the appellant was undergoing dialysis treatment three times a week and awaiting a kidney transplant. He maintained that article 3 of the European Convention on Human Rights ('ECHR') would be breached (inhuman or degrading treatment), if he was to be returned to India without giving him the opportunity to take up the donor offer and to remain in the UK long enough to recuperate.
5. The judge at first instance, while acknowledging the appellant's condition was 'undoubtedly very serious', found that the appellant was not close to death and that the appellant had failed to demonstrate he could not be guaranteed nursing or medical care in India. Consequently, the judge found no breach of article 3.
6. It is from the above decision that the history of this appeal flows. The Upper Tribunal concluded in November 2012 that the First-tier decision did not involve the making of an error of law, finding the judge had taken full account of the relevant case law in relation to health when removal is contemplated.
7. From there the matter proceeded to the Court of Appeal, where permission to appeal was granted on 24 March 2014 as part of a series of linked appeals, all concerning applicants suffering from 'grave medical conditions being effectively treated in the United Kingdom'.
8. The Court of Appeal found that the appellant had major kidney disease (otherwise known as end-stage kidney disease), together with depression and evidence of a risk of suicide. The appellant's hospital had indicated their willingness to assess the appellant for a live donor transplant. On 1 July 2014, the Court of Appeal found the proposed donor was compatible.
9. At that stage, the Secretary of State consented to the appellant's appeal being allowed and for the case to be remitted to the Upper Tribunal for further consideration of

his claim under article 8 of the ECHR. The Court of Appeal also indicated that the further development relating to the possible transplant might touch upon article 3 and the appellant could therefore make a fresh article 3 claim. As a result, the removal decision was quashed.

10. On 29 January 2015, the day before the Court of Appeal handed down its approved judgment, the appellant underwent a kidney transplant operation. The operation was successful, and he was discharged on 6 February 2015.
11. Although the appellant's appeal was remitted pursuant to article 8 of the ECHR, the appellant's article 3 claim, although acknowledged as above, was dismissed.
12. In common with the appellants in the other appeals before the Court of Appeal, the appellant sought permission to appeal to the Supreme Court on the article 3 aspect of his claim. Permission in that regard was refused on 30 July 2015. The parties then appealed to the European Court of Human Rights ('ECtHR').
13. His case by this stage had evolved to the following extent: the appellant argued that if he was now to be returned to India, where he would not have access to the ongoing, post-transplant expert medical supervision and medication that he required, the consequences would be catastrophic.
14. On 13 July 2017, the appellant's representatives were informed by the ECtHR that a single judge had examined the application and, having regard to the UK Government's undertaking to reconsider the complaint in the light of the Grand Chambers judgement in *Paposhvili v Belgium [GC]* [2016] ECHR 1113 ('*Paposhvili*'), the ECtHR had decided to strike out the application.
15. In short, the ECtHR did so because both parties agreed that the scope of the hearing before the Upper Tribunal would include consideration of both article 3 and article 8 of the ECHR.
16. On 26 January 2018, Upper Tribunal Judge O'Connor stayed the appellant's case pending a decision of the Court of Appeal in *AM (Zimbabwe) and others* (C5/2016/4178, C5/2016/4677 and C5/2017/0755). Various case management directions have since been given.
17. Subsequently, *AM (Zimbabwe)* has been decided and now appealed to the Supreme Court. It is due to be heard in December 2019. As part of the case management in this matter, the decision was taken that this case could now proceed, notwithstanding that outstanding appeal. Nothing in the course of the instant proceedings has changed our view in that regard for the reasons set out herein.

The present proceedings

18. On 16 February 2018, the respondent wrote to the appellant providing a supplemental letter, as requested by the Upper Tribunal, to be read in conjunction with the original decision of 8 May 2012. That letter states it is neither a fresh decision to refuse a human rights claim nor the rejection of further submissions as a fresh claim. It was essentially a letter to assist the parties in the current Upper Tribunal proceedings.
19. This matter was listed before us originally on 28 May 2019 and then adjourned for further directions, which included that the parties provide a summary of the issues they are now asking the Upper Tribunal to resolve.
20. In a statement of agreed issues, dated 28 May 2019, the appellant and the respondent indicated the following legal issues required resolution:
 - i. Article 3 - medical;
 - ii. Article 3 - suicide;
 - iii. Paragraph 276 ADE (1)(vi) of the Immigration Rules;
 - iv. Article 8 - private life.
21. Additionally, the appellant and the respondent agree the following new factual issue requires resolution, which it was submitted, impacted upon the above legal issues:

Whether or not the appellant is gay.
22. In order to resolve these issues, and because this is a remitted appeal, we are also charged with making findings of fact.
23. In coming to our decision, we have been greatly assisted by both Mr Kotas and Mr Eaton and their respective submissions and skeleton arguments.

Preliminary issues

Sensitive witness

24. On the basis of the medical evidence available, the appellant's representative submitted that the appellant should be treated as a sensitive or vulnerable witness in order to reduce any distress when giving evidence. We accept that. There is evidence of mental well-being issues sufficient for us to state at a preliminary stage that the appellant is vulnerable. We have made appropriate allowances in the appellant's evidence, pursuant to the 'Joint Presidential Guidance Note no. 2 of 2010 - Child, vulnerable adult and sensitive witnesses'.
25. Further, we implemented the adjustments suggested by his counsel, including ensuring that the appellant had regular breaks throughout the hearing, pauses for

relevant documentation to be shown to the appellant, we sat *in camera* while he gave his evidence, and it was explained that if there were any matters that he did not understand he should indicate.

Anonymity

26. The appellant's representative requested that anonymity was maintained. We were content to extend the anonymity direction given previously.

The evidence

27. We do not intend to index every piece of evidence we have considered in coming to our decision. We acknowledge the helpful consolidated bundle provided on behalf of the appellant, which includes not only the appellant's witness statements, but statements and letters from those supporting him, together with a medico-legal psychological report from Mary Robertson, dated 25 April 2018, together with other medical documents. The same bundle helpfully includes the documents referred to in the case history set out above, including the judgements and determinations that have been given in this matter thus far, the supporting documentation served on the Court of Appeal, the further medical evidence available at that time; and documents pertaining to the appellant's education, including his first class honours degree from the University of Madras, dated April 2008.
28. Also included within the appellant's bundle was a medico legal report by Dr E Zapata-Bravo, dated 5 December 2013, a consultant psychiatrist, and further reports relating to dialysis treatment. Finally, the bundle includes evidence in support of what is said to be the appellant's private life and the main authorities relied upon by the appellant's representative.
29. The respondent's bundle is subsumed within the appellant's bundle for these purposes. We underline that in a comprehensive bundle that extends to over 966 pages, we have considered the contents in their entirety when coming to our decision.
30. In addition to the above, we were provided with, both prior to the hearing and during it, five further bundles of evidence and submissions:
- i. Bundle A - a further consolidated bundle on behalf of the appellant containing evidence relating to the appellant's financial affairs, a bank statement in relation to his father, an email from his landlady, and evidence of the cost of medication in India, all of which were provided pursuant to further directions given by us.
 - ii. Bundle B - a clip of supplementary evidence provided on behalf of the appellant, which includes a further medicolegal report on the appellant, prepared by Mary Robertson, consultant and chartered clinical psychologist, on 18 July 2019, setting out her further opinion,

recommendations and prognosis. This also includes a letter from the appellant's solicitors explaining some of the difficulty they encountered when requesting information as to the availability of immunosuppressant medication and the cost of regular kidney checkups in India.

- iii. Bundle C - a response to the directions set by us, on behalf of the respondent. This includes an extract from the Secretary of State's extant guidance on arranging removal and further email enquiries regarding the cost of the required medication and the cost of private treatment in India.
- iv. Bundle D - an Internet printout in relation to the appellant's medication, and in particular Tacrolimus, as published by the National Institute for Health and Care Excellence, (NICE).
- v. Bundle E - a further response from one of the hospitals contacted in Chennai by the respondent.

31. We heard oral testimony from the appellant, and thereafter evidence from one witness, Ms R (otherwise R H, a British national). The appellant spoke good English and there was no apparent difficulty during the proceedings with comprehension. On 10 September 2019, we heard submissions from the parties before reserving our decision.

The standard and burden of proof

- 32. Where an application is made under article 3, the burden of proof for establishing the claim rests upon the appellant. The standard of proof is the so-called lower standard, namely that there is a reasonable chance or substantial grounds for thinking that the applicant would be at risk upon return.
- 33. The appellant also submits that the respondent's decision to refuse to grant him leave to remain breaches the UK's obligations under article 8 of the ECHR. The burden of establishing this rests upon the appellant and the standard of proof is the usual civil standard, the balance of probabilities.

The first issue: whether the appellant is gay

- 34. We deal with the appellant's sexuality first as our finding in this regard is likely to impact on our subsequent discussion.
- 35. This is a new aspect of the case that emerged after remittal by the Court of Appeal, (on which the appellant was not interviewed by the respondent). The respondent does not accept the appellant's claimed sexual orientation.

36. The respondent maintains that the appellant has been in the UK for some nine years and has litigated extensively to seek to extend his stay here. His witness statement, submitted for the hearing on 28 May 2019, was the first time he put before any tribunal (or the Secretary of State) his fear of return to India based on his sexuality. In short, the respondent advances that it appears strikingly convenient to raise sexuality as a reason to remain at this late stage.
37. The appellant, on the other hand, states that he has been attracted to the same sex from an early age and although his parents and family were unaware he is gay, he had had same-sex sexual relations both in India and the UK, although he chooses to keep these private. He is concerned about how his family and others might react, in part due to his Muslim faith.
38. The appellant states that he did not talk to his previous solicitor about his homosexuality because he was scared how she might react, as she too was from a Muslim Indian background. The appellant maintained that while he had not discussed this with his previous solicitors, he had mentioned it to his psychologist.
39. In submissions, Mr Kotas rejected the appellant's explanation in this regard, commenting that he was a highly educated man who would have realised the importance of such a claim, and that his solicitors would have been aware of their duty in terms of client confidentiality. He observed that there was little probative value in what he had told the psychologist, as those reports were based upon the appellant's own self-reporting; and further adds that there has not been any evidence adduced from other men to support this claim.
40. Mr Eaton referred us to the UNHCR handbook on Credibility, which addresses the reluctance of asylum applicants to disclose issues arising out of sexual orientation and the inability of trauma sufferers to disclose past trauma.

Our findings in relation to the appellant's sexuality

41. We agree that the timing of the disclosure raises legitimate concerns, bearing in mind the appellant, who has been ably represented throughout these appeals, made no mention of his sexuality in the extensive proceedings that preceded this matter.
42. Another difficulty we find is that the appellant's own disclosure of his sexuality in his witness statement is somewhat piecemeal. It is plain that his family believe he is heterosexual. His claim that he has had '*sex with a lot of guys in India and the UK, but not proper intercourse*', was not developed beyond the generality of his witness statement, with no information, for example, about what age he started having consensual relationships of this type or in what circumstances. While the appellant maintained that he watches a lot of gay pornography, there was little further explanation, with no reference to which websites he visited, and although in evidence he told the tribunal he used a gay phone app and had had physical relations 'every week' since 2011 or 2012, there was no corroboration of either.

43. The appellant's disclosure about his sexuality also has to be viewed in the light of what he had told the psychologist, Mary Robertson, during their first meeting in 2018. He gave her a portrayal of somebody who was embarrassed and shy about discussing his sexuality, confirming that he had never felt attracted to women, but was 'getting attracted to some men', although he felt bad about this. This hardly aligned with the more promiscuous account he now gave to us.
44. The psychologist concluded the appellant was struggling with issues relating to sexuality and had had deep feelings of shame and worthlessness as a result. She found that he was confused about his sexual orientation. It is apparent the appellant did not explicitly tell her that he was gay, although he alluded to this possibility several times, adding that being gay was a taboo in India. His reluctance to give her what he claims to be the true account dilutes to a large extent the opinion she gives in this regard - a theme we return to below.
45. The disclosure that the appellant had been to the London gay pride festival a couple of months prior to the hearing first surfaced in oral evidence before us, and on one view, bearing in mind he had experienced representation, was a notable omission from any statement he might have prepared.
46. Mr Kotas was correct to identify that the appellant's previous legal representation was not limited solely to a Muslim Indian woman and that in another medico legal report prepared by Dr Zapata-Bravo (a consultant psychiatrist) in 2013, the appellant was identified as heterosexual.
47. These factors, taken together, caused us to have considerable reservations about the evidence that the appellant now advanced. However, each of the above concerns needed to be balanced with the evidence in the round and the appellant's most recent account.
48. In terms of Dr Zapata-Bravo's 2013 report, while the appellant's sexual orientation was identified as heterosexual, it was added that he had had no sexual experience and had never had a girlfriend. We have looked at previous statements and the evidence provided to us within the bundle, including the judgments of previous courts, and at the extensive medical evidence, but found no firm reference to the appellant's sexuality therein. It is not an issue that appears to have been considered, and importantly for these purposes, we could find no evidence that contradicted the appellant's account. While the appellant's organ donor had commented in his witness statement that they had talked about the appellant meeting a woman and getting married, the donor added that as far as he was aware, the appellant had not looked for women in the UK and did not socialise a lot with women. The appellant stated he had lied in this regard to his friends in order to avoid embarrassment.
49. Further, when he saw Mary Robertson, he appeared uncomfortable about discussing his sexual identity and told her that he did not want her to disclose his

worries about his sexuality to his solicitor. This to an extent is consistent with what he has told us.

50. We also accept that the nature of the appellant's encounters with other men, if true, were likely to be difficult to prove. He explained that he might meet them casually in the street or at a train station and often would not even get their name. He said he had asked an 18-year-old to come along and give evidence, but he had declined. The appellant maintained he had never been in a long-term relationship.
51. In this regard, we also heard from his only witness to give evidence, RR. She had known the appellant since 2011, they having met because her maternal grandmother was also having dialysis at the time. She confirmed that the appellant had confided in her at an early stage that he was gay and that his concern was that her grandmother, as a practising Muslim, would find out. In evidence, she said she had had an instinctive feeling about his sexuality and had been with him in July when they went to London gay pride. Her general sense that the appellant was gay was based on the fact that he had made comments about men who were attractive and that he had confided in her about this. He had also confided in her about a sexual assault on him when he was younger. We found she gave a credible account for why she believed the appellant was gay.
52. We are satisfied that any feeling of embarrassment combined with his religious concerns may have been sufficient for him to avoid wishing to discuss or disclose the nature of his sexuality with those previously dealing with his appeals.
53. Having considered the evidence in the round, both on balance and to the lower standard, we answer the factual issue we are asked to consider in the following way: the appellant is gay. We return to the ramifications of this in terms of our judgment below.

The appellant's credibility generally

54. While we accept that the appellant is gay, we think it appropriate to express a view about the credibility of other aspects of the evidence dwelt on before us.
55. The appellant maintained he was indebted to a moneylender in India. His case was that he had not been able to repay the moneylender due to difficulties he had had working in the UK and that if returned to India, he would not be able to raise sufficient money to service his debt there. It was advanced that the moneylender had threatened both the appellant and his parents.
56. The appellant has been employed in the UK on a part-time basis for Pizza Hut since the end of 2011. In October 2017, he was encountered working as a shift manager during an enforcement visit. At that point he was viewed as an overstayer by the Home Office and this led to his work ending for a period. By Christmas 2018,

however, he was back working at the restaurant. His duties include being a 'meeter and greeter'.

57. His employment there has to be contrasted with what the appellant says about his indebtedness. The appellant maintains he comes from a very poor family in India. Statements from his father and others confirm this to be the case: *'We are living in extreme poverty'*.
58. In order for the appellant to be able to come to the UK, the appellant had to fund his trip. He maintains he did this in a number of ways: first, he borrowed a sum of around £1070 from a moneylender at a rate of interest of 5% per month (according to his father's undated and unsigned statement [p366 of the bundle]). Second, it is said that he pledged about 40 sovereigns of gold with a private pawnbroker. Third, it is claimed the appellant received jewellery from his family, which he took to the pawnbroker.
59. According to the written evidence of the appellant's father, the moneylender has been making threatening phone calls and this has caused him and his wife to change address 'very often'. His father states that the moneylender has threatened them with *'extreme consequences'* and also threatened that if the appellant were to *'set foot in India he would face the music'*; and that they are scared of making any complaint against the moneylender as they do not want to invite any police trouble.
60. The appellant's sister-in-law states that the sovereigns of gold came from her and her husband to fund the appellant's expenses going abroad. She also says she has not received back the jewels. She had expected the appellant to do well and take care of his family once abroad. That expectation was not fulfilled she says. According to the appellant's brother, these gold jewels have been sold by way of auction, leading to tension within the family.
61. We found the overall account to be deficient in a number of respects. There does not appear to be any mention of moneylenders in the appellant's parents first statement, dated 10 August 2012. The appellant was less than clear in his evidence about what had occurred, invariably switching from talking about the money lender to talking about the pawnbroker. While according to his brother and sister-in-law, not a single rupee had been paid to the money lender (or lenders) towards the loan, the appellant said that his mother had paid some money.
62. The pawnbroker receipts provided were equally difficult to follow. One was dated 8 June 2011 and one 8 October 2011, but the appellant had arrived in the United Kingdom on 9 September 2010. One was in the first name of this appellant and one was in the name of his mother. They did not mention gold sovereigns, but instead referred to what appears to be largely gold jewellery, including rings and chains. It was difficult to reconcile these receipts with the unspecified evidence of the relatives. While the appellant suggested that these were in some way duplicates, we found little by way of evidence to demonstrate that.

63. In our judgment, the appellant's account lacks proper explanation in terms of the detail of what had taken place in India. He estimated that he now owed about £7000.
64. A curious feature of his account was that the appellant also accepted that if he had £100 or £200 in his pocket, left over from his earnings in the UK, then he would spend it on himself. He readily accepted he had lent money to close friends during this period, including a holiday payment for £278. He said it was something that he and his friends often did. He added he had an iPhone and that his mobile phone was costing £100 per month. His bank statements revealed that he had bought the latest phone, visited the Watchstation, and there was evidence of him contributing towards various sundries, including petrol. He also had a Movieworld subscription for a year and there was evidence in his bank statements (as recently as April 2019) showing him going out to restaurants where he appeared at times to spend greater sums than, according to some of the evidence, his family members earned in a week. He explained that £200 did not make any difference to the debt and that he had not sent 'a penny back to his parents'.
65. We found his apparent disregard for the claimed debts to be difficult to reconcile with statements made by him elsewhere and those we had read from his family. It appeared incredible that, on the one hand, it was claimed his family did not have running water and could not afford meat; and yet on the other, he maintained that £50 or £200 would make no difference. It was apparent to us that the appellant was either being untruthful or was not providing the complete picture.
66. Similarly, in the documentary evidence that was provided by the appellant (Bundle B) there was a transcript of a conversation between a male and female. We were told that this was between the moneylender and the appellant's mother. There was no confirmation of this. It was unclear when this recording had taken place, but it was adduced as evidence to show the appellant was being threatened. There was no explanation for how or why the mother came to be recording this conversation, where it was recorded or on what.
67. We could place very little weight on this recording because it appeared to materialise without any proper evidential foundation. No precise sums of money were identified in the recording and the female appears to suggest at one stage that the caller will only have to wait a few days if they want their money back and that her son was returning. That was inconsistent with the appellant's case.
68. The purpose of this audio evidence was said to demonstrate that if the appellant was to return, his life would be at risk and that somebody was essentially targeting him as a result of the debt he owed. We are unpersuaded, even to the lower standard, about this. The fact remains that he had made no attempt to send any money back in the eight years he has been in the UK and (if any of it was true) was prepared to see his mother, who had supported him throughout his medical

procedures, subjected to hostile conversations and threats, being forced to move to a new house and living in extreme poverty, while he was earning and living relatively comfortably in the UK. The whole account lacks credibility on a number of levels, to the point of disbelief, and we find accordingly.

69. To complete the picture, the appellant also maintained that he had been borrowing money in the UK. The appellant accepted he had borrowed money off a Mr K, who he described as 'being like a brother' and as being 'well off'. The appellant told us that he had been in a desperate situation and really struggling to complete his studies, so as a gesture of goodwill Mr K had lent him £6000 towards his tuition fees. Mr K had done this by paying the college directly (although the appellant said he had no proof of the amount being paid). There was no record of any loan or agreement in this regard. It later transpired that Mr K ran some form of immigration consultancy, and that this was an open-ended loan with no interest – the main condition appeared to be that it would be paid back when the appellant found a good job. It later transpired that Mr K was now serving a prison sentence (although, notwithstanding Mr K being like a brother, the appellant did not know what for).
70. We again found this account to lack credibility. If there was money to be borrowed, one might have thought the appellant would have begun by furnishing the debt in India that was ruining his parents and leading to threats on their lives.
71. We conclude the appellant has fabricated his claim to have been financially supported here by Mr K in the light of his confusing 'open-ended' explanation and we place little weight on the letter from Mr K, whose motives or source of funding could not be explored.
72. It also appears that the appellant owes his landlady money, an individual he refers to as 'auntie'. His bank statements show random amounts of money being paid to individuals who he maintains he paid at auntie's request. It was again difficult to reconcile this aspect of the appellant's evidence. There was no proper explanation for why auntie would ask the appellant to pay his rent to third parties, instead of her, or why she could not have then paid the third parties herself.
73. While we have been careful to bear in mind the appellant's vulnerability in terms of his depression, anxiety and low mood and that for some of this period he was undergoing surgery, together with the supporting evidence from his family members and others who know him, we are nonetheless driven to the view that the appellant has embellished his account concerning the debt in India and the UK; and painted a false picture of his relationship with his indigent parents whom he has not supported financially despite their alleged problems and his lengthy period of employment and apparent lifestyle in the UK.

The second issue: Article 3 - health

74. The appellant submits that his removal to India would breach his rights under article 3 of the ECHR on medical grounds. It is advanced that in *Paposhvili*, the Grand Chamber found that there were other exceptional circumstances that may give rise to an issue under article 3, in addition to the circumstances considered in *N v UK* (2008) 47 EHRR 39. In this regard, it is maintained that the appellant's circumstances are very exceptional, as without the post-transplant care and treatment he requires, he is at risk of decline to the extent that it would result in intense suffering and/or a significant reduction in life expectancy.
75. Reports were produced from two individuals, Ms L Kumaraswami and Dr David Game, (the latter being the appellant's consultant nephrologist), to explain the treatment the appellant requires post-transplant and to help confirm that this would not be available to him should he be returned to India.
76. It was further maintained that the appellant would not be able to afford immunosuppressant medication in India. This was due to the appellant's major depressive disorder and him having moderate levels of anxiety, which, it was said, would impact on his ability to access work and services in India; and that his family would not be in a position to provide any more than the most basic level of support as a result of their impecunious circumstances and the debts owed in India and the UK.
77. Taken together, it was submitted this would lead to a potentially life-threatening rejection of his kidney transplant.
78. Mr Kotas, on the other hand, maintained that the Court of Appeal in *AM (Zimbabwe)* has made clear that for domestic purposes, the *N v UK* standard still applied when considering article 3 medical cases, and that the appellant's case came 'nowhere near' that standard: he does not face an imminent risk of death if removed to India.
79. Mr Kotas further argued that the appellant's kidney transplant had been successful and that he was in good overall health. The appellant's own expert, it was suggested, confirmed the main immunosuppressant drug (Adoport Tacrolimus or an equivalent) was available in India (it was conceded that the brand of immunosuppressant the appellant took was not available, but an alternative brand was). There were several hospitals in Chennai, it was said, with specialist nephrology departments that the appellant would be able to approach. Therefore, there would be no breach of article 3. The lack of monitoring of the appellant's health would not entail a breach of article 3.

Our preliminary findings: Article 3 - health

80. The first relevant finding we make in this regard is that on 29 January 2015 the appellant received a kidney from his donor and that that operation was described

by Dr Game as 'straightforward for donor and recipient', that the kidney worked immediately, and the appellant was discharged on 6 February 2015.

81. We further find that there were no post-operative complications. His transplant function was described as 'excellent' and at the time of Dr Game's letter of 9 March 2017, it was remarked that there were no other major health issues. It was estimated that the kidney would last him about 15 - 20 years, although it could be longer or much shorter than this.
82. The appellant continues to have regular follow-up treatment following his kidney transplant, involving quarterly appointments with his consultant and a regular prescription of immunosuppressants. Failure to take this medication post-transplant, it was stated by Dr Game, would lead to a risk of rejection. We find accordingly.
83. It was accepted by Mr Eaton that the medication required by the appellant (or a generic alternative) was available in India. We also find accordingly.
84. In terms of physical health, the issues between the parties essentially came down to how the appellant would afford the medication and secondly, how accessible or available that treatment would be to him.

The law: Article 3 - health

85. In *AM (Zimbabwe) & Anor v The Secretary of State for the Home Department* [2018] HRLR 9, [2018] Imm AR 737, [2018] EWCA Civ 64, [2018] 1 WLR 2933, [2018] WLR(D) 56, [2018] WLR 2933 ('*AM (Zimbabwe)*') the Court of Appeal considered the application of article 3 in the context of individuals who were suffering from serious illness following the judgment in *Paposhvili*. The Grand Chamber in *Paposhvili* had concluded the application of article 3 in cases only where the person facing expulsion is close to death (the practice since the judgment in *N. v. UK*), had deprived some individuals who were seriously ill, but whose condition was less critical, of the benefit of article 3.
86. The Chamber found that the "other very exceptional cases" identified in the judgment of *N. v. UK* should be understood to refer to situations involving the removal of a seriously ill person in which substantial grounds had been shown for believing that he or she, although not at imminent risk of dying, 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, which extended to the need to consider the cost of medication and treatment, the existence of a social and family network, and the distance to be travelled in order to have access to the required care, to avoid 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.

87. The above conclusions however need to be read in the light of the Court of Appeal's decision in *AM Zimbabwe*. In considering the extent of the change in the law following the judgment in *Paposhvili*, as compared with the judgments in *D v UK* (1997) 24 EHRR 423, and *N v UK*, Sales LJ found it was clear that *Paposhvili* relaxed the test for violation of article 3 in the case of removal of a foreign national with a medical condition, but 'only to a very modest extent' (para 38). The scope of the phrase "very exceptional circumstances" had previously been settled by the House of Lords in *N (Uganda) v Secretary of State for the Home Department* [2005] UKHL 31; [2005] 2 AC 296 ("N"), where the House of Lords held that the protection of article 3 against removal in medical cases is confined to so-called "deathbed" cases where death is already imminent, with Lord Hope stating [50]:

"... For the circumstances to be ... 'very exceptional' it would need to be shown that the applicant's medical condition had reached such a critical stage that there were compelling humanitarian grounds for not removing him to a place which lacked the medical and social services which he would need to prevent acute suffering while he is dying..."

88. This test was endorsed by the Grand Chamber in *N v UK*.

89. The consequences of *Paposhvili* for medical cases in which there is reliance on article 3 has been considered by the Court of Appeal in not only *AM (Zimbabwe)*, but also *SL (St Lucia) v Secretary of State for the Home Department* [2018] EWCA Civ 1894 ("SL (St Lucia)"); *MM (Malawi) and MK (Malawi) v Secretary of State for the Home Department* [2018] EWCA Civ 2482 and *Secretary of State for the Home Department v PF (Nigeria)* [2019] EWCA Civ 1139 ("*PF (Nigeria)*"). These endorse the general principles set out in the judgment of Sales LJ in *AM (Zimbabwe)*.

90. In *PF (Nigeria)*, the Court of Appeal set out the following propositions to be drawn from the cases (para 19):

"i) Despite the guidance given in *Paposhvili*, as a result of the principle of stare decisis (i.e. the usual rules of precedent in this jurisdiction), the test in *N* remains binding on this court, and indeed all tribunals and courts in this jurisdiction, subject only to the Supreme Court using its power to overrule it (see *AM (Zimbabwe)* at [30], *MM (Malawi)* at [9(i)] and the aptly entitled UT judgment in *EA and Others* (article 3 medical cases - *Paposhvili* not applicable) [2017] UKUT 445 (IAC)).

ii) *Paposhvili* at [183] relaxes the test for violation of article 3 in the case of removal of a foreign national with a medical condition (see *AM (Zimbabwe)* at [37]-[38], and *MM (Malawi)* at [9(i)]). Having quoted the relevant part of [183] of *Paposhvili*, Sales LJ put it thus in *AM (Zimbabwe)* at [38]:

"This means that where the applicant faces a real risk of experiencing intense suffering (i.e. to the article 3 standard) in the receiving state because of their illness and the non-availability there of treatment which is available to them in the removing state or faces a real risk of death within a short time in the receiving state for the same reason. In other words, the boundary of article 3 protection has been shifted from being defined by imminence of death in the removing state (even with the treatment available there)

to being defined by the imminence (i.e. likely ‘rapid’ experience) of intense suffering or death in the receiving state, which may only occur because of the non-availability in that state of the treatment which had previously been available in the removing state.”

In that passage, Sales LJ was expressly paraphrasing *Paposhvili*, not seeking to redefine it in any way.

iii) Whilst *Paposhvili* marks a relaxation of the test, Sales LJ considered “it does so only to a very modest extent”: the article 3 threshold in medical cases remains high (see *AM (Zimbabwe)* at [41]-[42], and *MM (Malawi)* at [9(iii)]).

iv) There is a switching burden of proof (see *AM (Zimbabwe)* at [16], and *MM (Malawi)* at [9(iv)]). As Sales LJ put it in *AM (Zimbabwe)*:

“It is common ground that where a foreign national seeks to rely upon article 3 as an answer to an attempt by a state to remove him to another country, the overall legal burden is on him to show that article 3 would be infringed in his case by showing that there are substantial grounds for believing that he would face a real risk of being subject to torture or to inhuman or degrading treatment in that other country: see, e.g., *Soering v United Kingdom* (1989) 11 EHRR 439 at [91], which is reflected in the formulations in *Paposhvili* at [173] and [183].... In *Paposhvili*, at [186]-[187]..., the Grand Chamber of the ECtHR has given guidance how he may achieve that, by raising a prima facie case of infringement of article 3 which then casts an evidential burden onto the defending state which is seeking to expel him.”

91. On any clear reading of the above authorities, the legal test remains aligned to *N v UK* with the Strasbourg Court only relaxing the test to a very modest extent. As explained at the outset, we are conscious that *AM (Zimbabwe)* has yet to be decided by the Supreme Court, but we are content to proceed on the basis of the approach outlined above.

Our further findings: Article 3 - health

92. In the evidence before us there is reference to country information for India and medical issues, (Kidney Failure: dialysis 17 October 2016), which states, according to the website of the India Renal Foundation, that there are about 500 hemodialysis centres in India and about 3000 dialysis machines. It also states there is extensive nephrology treatment facilities and that the medication is widely available. This reflects the first tribunal judge’s finding in July 2012 that the country guidance at the time demonstrated the availability of treatment.
93. This accords in part with the evidence provided by Ms L Kumaraswami, in a letter dated 19 June 2015, supplied as part of the appellant’s bundle. Ms Kumaraswami is a founder of a charitable trust set up to help underprivileged people suffering from kidney problems. She confirms that the appellant would not be able to access free treatment in a government hospital, something we accept. She adds, however, that the appellant will be able to access the medication he requires, although this will have to be bought and paid for. We accept this. She also confirms that free dialysis is possible if the appellant gets a health insurance card issued by the government

for below poverty line patients and should there be a vacancy for a new patient. She adds that posttransplant care is available in major hospitals in Chennai and Mumbai.

94. The evidence from the Home Office confirms that the medication and nephrology support would be available in India. For the above reasons, we find accordingly.
95. We are therefore satisfied that the post-transplant treatment the appellant requires is available and that there are hospitals in Chennai and elsewhere where he could receive treatment. It would require the appellant to make appropriate enquiries, but on the basis that he is an intelligent functioning individual, currently working, and with a Master's degree, we find he would be able to do so.
96. The refined test in *Paposhvili* requires consideration of whether the appellant would be able to afford his immunosuppressant medication in India and the post-operative treatment available. While the appellant's representative maintains he would not, we find that this assertion requires further explanation. The additional evidence provided by the appellant's solicitors is disappointing in that it fails to give the tribunal a clear indication of what they say the cost would be in comparison to any estimate of the appellant's potential earnings. We return to this below.
97. The costings we have been supplied with, from both sides, vary, but there are some similarities as seen below:
 - a. One response suggest that 1 mg tablet may cost 30 - 50 Indian rupees (50IR = 58p), and regular checkups 'should not cost much' although the figure was not provided.
 - b. The respondent also provided evidence that the approximate cost of 3 mg capsules of 100 is 13,000 Indian rupees and the basic blood tests would cost between 1800-2000 rupees. The consultation fee would be ₹1000 per visit. While we were only able to work on approximates, at an exchange rate of 1 rupee equaling £0.012 (source: google, as quoted before us), the above figures equate to £149.68 for 100 3mg capsules; £23.03 for a blood test; £11.51 for a consultation.
 - c. The Net-meds evidence provided by the appellant showed the medication to be in stock and to be around ₹397 for 5 x10 capsules (£4.35)
 - d. In a letter of 28 July 2017, his previous solicitors, had suggested that 10 tablets would cost ₹255, equivalent to £2.94. They estimated that he would also have to pay ₹255 for Mycophenolate (a drug used with other medications to help prevent the body from rejecting kidney transplants). They also estimated that he would have to pay ₹1000 to meet with a specialist and that separate posttransplant tests would be between ₹2000 and ₹5000. ₹5000 is £57.57.

- e. Ms L Kumaraswami states she estimates transplant checkups to cost between ₹20,000-₹22000. After which a person has to pay ₹8000-₹10,000 per month. These figures were not reflected elsewhere, but ₹22,000 amounts to £253.30 on the exchange rate we were given.

98. The letter of Dr Game, dated 9 March 2017, confirms that the only medication the appellant is on in relation to his immune suppression is Adoport, twice daily, lifelong. We understand the appellant takes 6 mg per day. Dr Game also confirmed that the maximum time between appointments is four months. We accept these elements of his evidence.
99. Doing the best we can, we therefore estimate that the cost to the appellant for a quarterly checkup would be the sterling equivalent of £12.00 based on two of the estimates we received (£48 per annum); accepting the figure of £149.68 for 100 3mg capsules (50 days supply), the cost of 6 mg of tablets a day would be approximately £2.99 ($\frac{£149.68}{50} (£2.99) \times 365$) = £1092.66 per annum. Plus, we calculate a further amount for post-transplant tests, 3 times a year at £57.57, totaling £172.71.
100. While we accept that these figures are approximates, we estimate an annual cost of something akin to £1313.37, which we round up in the appellant's favour to £1400 or £116.66 per month. We find accordingly. The appellant's counsel estimated the cost of the medication to be over £100 a month. It was suggested that this was prohibitively expensive.
101. In terms of the appellant's potential income, we were given very little by way of information. We were taken to one statement where a relative doing contract work was earning between £100 and £132 per month. It was suggested this was a benchmark in terms of earnings. We were told there was no country guidance information on income for graduates.
102. We were not persuaded about the comparison with the relative. The appellant is fluent in English, having been to an English speaking school and having lived in the UK and studied in the UK for several years. He has hospitality and other business experience; he has a first class honours degree and a masters degree; and he has shown himself to be a resourceful individual in terms of work and making contacts while in the UK. He has an offer to stay with his parents. He is therefore well placed to source gainful employment in India. Indeed, the appellant's home area is a large and populous city. He previously worked for a multinational company, earning £100-130 per month, according to his statement of 6 March 2014. If correct, we were entitled to assume that with his improved qualifications his earnings would be higher and these could be used to pay for his medication and monitoring.
103. We agree with Mr Kotas that there is no reason to assume these costs will be prohibitive. The burden was on the appellant in this regard.

104. While the appellant suggests that he has debts in the UK and owes money in India, and therefore could not give his medication and treatment priority we reject that proposition. First, if true, he has hardly given these debts priority until now. Second, we have already explained in some detail why we rejected his account relating to debt. It lacked credibility.
105. We also reject the suggestion that the appellant's mental health would prevent him from working or finding work in India. It has not so prevented him from doing so in the UK. Part of his mental health issue was said to be linked to his immigration status and these proceedings. This would, in our view, be alleviated on his return. Further, he would have family support and a social network. We return to this aspect of his claim below.
106. We are therefore satisfied that the medication he requires is affordable and that there are hospitals in Chennai and elsewhere where he could receive treatment. Bearing in mind he has not, on his evidence, had a check-up for eight months, he could take steps now to ensure he did not require an immediate checkup upon return. Further, he could have planned for any return through accumulating some savings (from his permitted work in the UK).
107. It was not advanced before us that the distance to be travelled in order to have access to the required care would be prohibitive, and we find it would not be. There is treatment available in Chennai. The transplant went well and there were no signs of any acute rejection. As a result, we did not find it necessary to consider what may happen, possibly at some future point, as that would require us to speculate.
108. In our judgment, while taking into account as we do the underlying mental health issues and the difficulties any person returning to India may face initially in establishing their medical care, we find no prospect of the appellant being exposed to a serious, rapid and irreversible decline in his health resulting in intense suffering or to a significant reduction in life expectancy or to acute mental suffering.
109. The article 3 threshold in our judgment is still very high; and the appellant's case falls far short of it. Dr Game expressed the view that the appellant's health and life expectancy are likely to be best served by him remaining in the UK, but added that if the appellant had access to an appropriately trained transplant team and all the same medications, investigations and treatments that are currently available to him that this would be reasonable. We find that this is the case here. There is no imminence of death and there is no imminence of death due to lack of treatment or medication in the receiving state. We respectfully adopt Sales LJ reasoning that the Grand Chamber at para. [183] in *Paposhvili*, used the rubric "other very exceptional cases", to indicate how rarely the test in article 3 will be found to be satisfied in medical cases, emphasising in the final sentence that it was still intending to indicate that there was "a high threshold for the application of article 3" in medical cases. We do not consider the appellant meets the threshold in *N(Uganda)* nor the more "relaxed" test in *Paposhvili*.

110. It follows that, having regard to the treatment available in India and the evidence in the round, the removal of the appellant to India would be proportionate.

The third issue: Article 3 – suicide

The respective submissions

111. Mr Eaton relied upon the medicolegal report of Mary Robertson, a chartered and consultant clinical psychologist, who found that the appellant suffered from a major depressive disorder and suicidal ideation, and that in her view, the appellant ‘will be at very high risk of suicide if faced with return to India’. It was advanced that the appellant had recurrent suicidal thoughts and had enunciated a clear plan for executing this, namely an intention to bite or sever the fistula in his arm to cause a fatal hemorrhage. It was further suggested he had made one previous attempt on his life and that he would not resist taking his own life if he was required to return.

112. It therefore followed, it was advanced, that the appellant faced a very real risk of an article 3 breach due to the risk of suicide; and that the evidence would strongly suggest that, at least initially, the suicide risk would be domestic. Mr Eaton cited case law including *SP (risk, suicide, PTSD, IFA, medical facilities) Kosovo CG* [2003] UKTI 80 00017 and *Y and another (Sri Lanka) v Secretary of State for the Home Department* [2009] EWCA Civ 362.

113. Mr Kotas acknowledged that Ms Robertson had put the appellant at high risk of suicide should he be removed to India and that she took the view the risk would be high at all stages of the removal process. He contended, however, that the high threshold for a suicide claim was not made out; the appellant’s fear of return to India was always based upon, and was inextricably linked to, his belief that he would not be able to access medical treatment in India. Mr Kotas submitted such a belief was wholly without foundation. It was one based on perception or assumption.

114. Further, Mr Kotas maintained that the claimed fear of having to return as a gay man and having the inability to repay debts were not matters that could themselves give rise to a successful claim of risk of suicide.

115. It was also argued before us that we could be satisfied to the requisite standard that the respondent had adequate mechanisms in place to ensure the appellant could be safely escorted back to India, pursuant to the evidence provided by the Home Office to support this (Bundle C ‘Arranging removal’, version 2, 4 October 2018).

The law: Article 3 – suicide:

116. The Court of Appeal in *J v SSHD* [2005] EWCA Civ 629 (*J*), considered the approach to a claimed risk of suicide, setting out the application of the 'real risk' test. That provides that if there is a suicide risk, it must be a real risk, (more than 'not fanciful').

117. Having regard to the way the ECtHR has applied it in different circumstances, the following guidance was provided in *J*-

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* paragraphs [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 paragraph [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 paragraph [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, in 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 clear in paragraph [49] of *D* and paragraph [40] of *Bensaid*.

29. Fourthly, an article 3 claim can in principle succeed in a suicide case (paragraph [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.

118. We further remind ourselves of the analysis on the mechanism of return in *J* –

61. As regards the risk of suicide en route to Sri Lanka, the IAT's finding was not perverse... They made it clear that the authorities in the UK would be involved in the arrangements. The IAT were entitled to infer that the Secretary of State would take all reasonable steps to discharge his obligations under section 6 of the Human Rights Act 1998 ("the 1998 Act"). As the IAT said in *AA v Secretary of State for the Home Department* at paragraph [39]:

"Third stage-transit: there are no reasons to suppose that the Secretary of State would not provide appropriately qualified escorts. This is known to be done. Other measures in other cases may include accompanying family members."

62. In our judgment, the IAT were entitled to take judicial notice of the arrangements that, no doubt conscious of his obligations under section 6 of the 1998 Act, the Secretary of State makes to escort vulnerable persons who are removed to their countries of origin. This is reflected in a document that we were shown which sets out Home Office policy for dealing with claimants who threaten suicide.

63. As regards the criticisms made of the finding in relation to the risk upon arrival in Sri Lanka, the IAT were entitled to conclude on the evidence before them that the appellant would have family support on his return to Sri Lanka. Having regard to the very high threshold for article 3 in foreign cases of this kind, the IAT's decision cannot be characterised as perverse. In particular: (i) the adjudicator had found that any subjective fears which the appellant might have on return were not objectively justified; (ii) he would have family support on his return; and (iii) he would have access to medical treatment in Sri Lanka which it was conceded was adequate...

Our findings: Article 3 – suicide

119. The appellant's alleged suicide risk is based on a number of factors: concerns over the nature of the medical treatment he would receive in India; concerns about the debts he has accrued and any risk that may be involved in his return; fears and concerns surrounding his sexuality; and concerns about his mental health and memory loss.

120. In considering the above, we return to the appellant's credibility and his propensity to mislead.

121. While we should be slow to distance ourselves from the views of an expert psychologist, in the instant matter we find the 2018 report of Mary Robertson to be based on a real misapprehension of the facts.

122. First, we have already commented on what we find to be a misleading account given by the appellant about his sexuality. While the appellant discloses that he was becoming attracted to men, he makes no reference to the men he apparently saw every week for sexual relations. His account that he believed his lower

testosterone level might be causing him to become attracted to other men is, to say the least, economic, if what he told the tribunal in other respects is true. The appellant was fully aware of his sexuality. To that extent the conflict and difficulties that Ms Robertson refers to when considering the appellant's sexuality do not arise; and her opinion concerning the need to resolve them is misplaced.

123. Second, Ms Robertson referenced the appellant's previous suicide attempt as a factor. The evidence given to us of the appellant attempting to drown (in an undated letter found at page 336 of the bundle) suggests the suicide attempt occurred at a time the appellant was not working, and so had decided to go to the nearest swimming pool to bathe. His friend records what happens as follows, although cannot recall the date:

He was swimming in the pool, after a few minutes of swimming he was trying to close his nose and going down the pool which I thought he was playing initially, after a few minutes he wasn't coming out from the pool, so I tried to call him and ask him to come out which he don't listen and continue staying inside the pool. So then I got scared and used my both hands to lift him up. (*sic.*)

Later, I took him out and went out to the nearest McDonald's for snacks and to speak to him why would he try to do that. So then I found he had many problems in back home and his personal problems which he wasn't explaining to me very clearly, so tried to drown himself in the pool. I got scared and advised him to speak to his solicitor or his GP regarding this so they can advise him and not to do this kind of silly thing in the future for the problems he facing now. (*sic.*)

124. This was not an incident that required medical, hospital or major intervention. There was no attempt at biting his fistula. We do not know what Mary Robertson would have drawn from this had she been given the complete picture.

125. Third, Mr Kotas also raised a question about the alleged suicide plan. His GPs notes suggest that in February 2016 the appellant had a fistula removed from his arm. The appellant said that was not correct and it was still held. It was not clear to us to what extent Mary Robertson had investigated this, or whether she simply accepted the appellant's account.

126. Fourth, while it is apparent that Ms Robertson was aware the appellant had a social life and had made friends in the UK, it is unclear if she was aware how extensive it was, and that at least one of his friends refers to being introduced to the appellant through a group of friends who regularly meet each other with a common interest to participate in social debates, charitable work and 'a generic desire for having influence on society to make it a better place'. Another friend states the appellant is always willing to help people and does domestic chores and shopping for a friend. Further, it is now apparent that the appellant felt sufficiently confident to be able to pick up men in the street on a regular basis and attend London gay pride. Mary Robertson may have come to very different opinion about his behavioural disengagement had she been fully aware of these factors.

127. Fifthly, we had concerns about the way the appellant's self-reporting was reflected in Ms Robertson's report. While he self-reports feeling restless and agitated, that his appetite is not good and that he had low mood and feelings of guilt, scoring on the Beck's Hopelessness Scale 18, indicative of severe hopelessness and suggesting a high suicide risk, however reliable these tests were said to be, we need to approach these results with considerable caution in the light of the appellant's propensity to mislead.
128. Sixth, the appellant relied on family debt as an additional stress factor, but here too we have found his evidence not credible.
129. In short, we found the appellant's account of his mood and emotional state to Mary Robertson, and indeed to us, to be often untruthful and therefore unreliable. It did not properly reflect other aspects of his life and we are not satisfied, even to the lower standard and bearing in mind as we do the sensitive nature of this evidence, that he gave a truthful account to Ms Robinson about his feelings and any suicide risk. This leads us to place little weight on the conclusions of the report in this regard.
130. We gained a similar impression from Ms Robertson's subsequent report, dated 18 July 2019. Again, she appears to accept statements made by the appellant, such as that he did not recognise or remember her from the previous year, without particular challenge; and she was accepting of his self-assessment for a major depressive disorder in the very severe range, on the basis the test was reported as being highly reliable. Ms Robertson does not adequately explain how it is that the appellant has made such progress in acceptance of his sexuality in one year (based on the misleading presentation in 2018) nor does her report appear to give appropriate mention of the positive changes in his life, such as his re-employment or the active social life he leads. On occasion she strays into advocacy, rather than a critical analysis of the appellant's mental state e.g. she suggests it is likely that the appellant would show significant clinical improvement with the appropriate treatment and if granted permission to remain in the UK. Her prescription in both reports appears to turn to an extent on the grant of leave.
131. There was little or no evidence to suggest the appellant has sought the further counselling or psychiatric support recommended by Ms Robertson. Although we accept that people who are withdrawn tend not to engage, and thus perhaps stop going to their doctor, or taking medication and pursuing alternative treatments, these factors also had to be weighed in the light of what has since happened. Following the suggested attempted suicide incident and the first report of Ms Robertson, the appellant had taken a job meeting and greeting diners, socialises regularly, uses public transport, dines out, goes to the cinema and on trips and attended the gay pride event. As a result of Ms Robertson being given an incomplete picture, there was no proper consideration in the 2019 report of the

possibility that the appellant was not submitting to counselling because he did not feel the need.

132. While Ms Robertson recommended psychological treatment, cognitive behavioural therapy or interpersonal therapy for his depression once his immigration matter was resolved, we could not see, if there was a real risk of suicide, why there needed to be a delay. Until then she had recommended a combination of supportive counselling and crisis intervention 'if the suicide risk escalates', but there is no evidence that that has taken place.
133. As stated above and for the reasons provided we give only limited weight to Ms Robertson's reports. We accept that elements of the account the appellant gave to Ms Robertson in 2018 and 2019 bear a semblance to the truth, including his success at school, and we accept that the appellant does have some mental health issues, including low mood and anxiety linked in part to his immigration status, which we take appropriately into account for the purposes of this appeal. We also make allowance for the appellant's claimed reluctance to disclose the full nature of his sexuality due to embarrassment or judgement and his vulnerability and other well-being issues.
134. The propensity to mislead had arisen in a previous encounter the appellant had had with a healthcare professional. In September 2013, the appellant had seen Dr Zapata-Bravo, a psychiatrist. In our finding, the appellant once again failed to give the complete picture when it came to his sexuality. If he had done so, Dr Zapata-Bravo would not have recorded the appellant as being heterosexual. Further, the appellant reported in 2013 that he had had a happy childhood and his extended family always 'lived together in happiness and peace'. This has to be contrasted with the account he gave to Mary Robertson, where she recorded an unsettled and unpleasant childhood, with him witnessing regular beatings of his mother, and where he also suffered serious beatings during which his father would hit him and throw him across the room 'like an animal'. Both accounts cannot be correct.
135. A similar tension arises in relation to the appellant's claimed sexual abuse as a child. While we do not need to resolve that issue, and would be slow to do so as a result of the sensitive nature of such a claim, we simply note that on the one hand the appellant maintained to one healthcare professional he had had a happy childhood and that the relationship in his parental family 'was harmonic' and that this also applied to his extended family, while he relayed to Mary Robertson an incident of rape by a distant cousin when he was aged 10 and regular beatings.
136. Although there were a number of references to the appellant complaining about memory loss, not only to Mary Robertson, but to Dr Game and Dr Zapata-Bravo, we are unpersuaded, even to the lower standard, about the appellant's assertions in this regard. It was apparent that he had a clear recall of certain events, but his recall became less clear when points of tension in the evidence arose e.g. over the debts or his sexuality. We found this to be significant. We did not accept that it was as a

result of a rare side effect of his medication. There was little evidence for that. Dr Game, his consultant nephrologist, in a letter dated September 2018, wrote that the appellant's memory difficulties are more likely to be due to his mental state rather than his medication or physical condition. We accepted this to a degree, but still saw scope for the appellant to exaggerate any claims in this regard.

137. We do not believe that the alleged debt and associated problems is such a determinative factor in terms of the risk of suicide. We have already explained that we do not find the appellant's account credible in this regard. The appellant appears to have managed to live fairly well without attempting to service this debt to date. We did not accept that 'his chickens would come home to roost' in terms of the debt. Nor did we accept that this in some way combined with other factors, such as any inability to find work or pay for medication, would raise the prospect of a suicide attempt either in this country or on arrival for the reasons already given.
138. Having considered Ms Robertson's reports in terms of the risk of suicide and what we considered to be the flaws in her conclusions, we also looked elsewhere for support for the article 3 claim. The risk of suicide had been identified by Dr Zapata-Bravo in 2013. This provided some consistency, but also left some issues unresolved. In 2013 the appellant's risk of completed suicide was said to be low because that was a quiet period pending Home Office decisions. Dr Zapata-Bravo identified that the appellant had a well meditated suicide plan to be activated in case of an adverse decision, including impending removal. Part of the issue was that Dr Zapata-Bravo believed the appellant would rather die in the UK than in India because of the lack of medical care available in India, as dialysis centres were predominantly in the private sector there. Dr Zapata-Bravo felt this would lead to an exacerbation of the appellant's depressive disorder, which together with his prepared suicidal plan, would make the risk of suicide quite high. Further, Dr Zapata-Bravo found that if he were to be removed, his mental health would also deteriorate.
139. In our finding, the appellant has had no experience of medical care relating to dialysis/post-transplant treatment in India, which means his perception is based on an assumption. We have already found that the appellant's misgivings about the health care available in India lack foundation, and therefore the concerns raised in 2013 are not objectively well-founded.
140. We also found his claimed fear on return in terms of his sexuality was not objectively well-founded. It would not be unreasonable to expect the appellant to relocate to another part of India away from his family or indeed another urban city if he felt unable to live as a gay man in Chennai itself. This is especially so given that the appellant was prepared to leave his family behind and relocate to a foreign country.

141. We also agree with Mr Kotas's submission in this regard. The appellant maintains that he is not especially close to his family and is no longer in regular contact with his mother, making internal relocation more reasonable still. We can find nothing unreasonable or for that matter harsh in the appellant internally relocating, either to find better paid employment (to cover rent, living and medical treatment) or to avoid any perceived discomfort or unpleasantness from his family because he was gay. We accept that considering the extant country guidance case *MD (same-sex orientated males: risk) India CG* [2014] UKUT 65 (IAC), there is no prospect of the appellant showing his fear on return was objectively well-founded in this regard.

142. In our judgment, any suicidal ideation is not genuinely held and is no more than an assertion. It previously has been linked to decisions to decline leave to remain. The appellant has no history of having harmed himself as a result of the decisions issued thus far. On 15 October 2014, the Department of Psychological Medicine at Guy's Hospital wrote to the appellant's then consultant nephrologist. The conclusions drawn, albeit five years ago, resonated with the tribunal:

Since the diagnosis, he has had two applications to remain in the country rejected by the UK Border Agency. On both occasions, he felt that he was given false hope by his legal representative. When he received the news that his application had been rejected, he recalled having thoughts about ending his life. He had considered cutting open his arteriovenous fistula. He also recalled that part of him wanted to continue living, which overrode his fleeting suicidal thoughts. It was around the time of one of his visa application rejections that he was referred to a clinical psychologist through your service, whom I believe, explored these feelings further. He was later discharged by the psychologist once his mood improved.

143. Also in 2014, Dr Humphrey, a hospital psychologist, gave the following similar report to the appellant's then nephrologist:

[The appellant] has no past history of any mental health difficulties. His periods of low mood and fleeting suicidal ideation seem to be in the context of coming to terms with his diagnosis and the UKBA decisions to decline visa extension or leave to remain. He has no history of having harmed himself or attempted suicide in the past. This was confirmed through liaison with his GP.

...

He stated that he was a somewhat naughty and funny child. He described having a very happy childhood.

...

There is no current evidence that [the appellant] is currently suffering from a mood or anxiety disorder. It seems that his documented suicidal ideation in the past seems to be very clearly in the context of his application to remain in the country being rejected. In addition, at this time he was not aware that he would be eligible for a living donor renal transplant. [The appellant] is very keen to point out that the situation is very different at present in that he has a stronger application and better legal support.

...

...There is certainly no current evidence of an underlying mental disorder. His future risk of self-harm, however, may change if [the appellant's] appeal to remain in the

country is rejected given the dire consequences that this may have on his future health....In the unlikely event that his appeal is rejected [the appellant] has agreed to be urgently reviewed in our clinic in order to assess his mental state and formulate a risk management plan...

144. These two opinions in our judgment, notwithstanding the passage of time, portray a greater objectivity; and undermine to an extent Mary Robertson's conclusion, which we have already explained attract little weight. We have already indicated that future health provision should be available to this appellant.
145. Our duty is to assess the risk of suicide on the date of the hearing. The appellant had no previous history of mental health problems prior to his immigration claim. He has had a successful transplant and is now, on one view, in a position to move forward with his life. Dr Game reports that otherwise medically 'things are rather good' and his kidney function is 'excellent'. We nonetheless accept he is depressed but not seriously so. We accept he has anxiety, which inevitably his immigration status has contributed to; but these subjective fears are not objectively well-founded. While we recognise that an article 3 claim can in principle succeed in a suicide case, this is not a matter where a real risk exists to the extent that removal will breach article 3.
146. In so concluding, we have considered *Y & Anor (Sri Lanka) v Secretary of State for the Home Department* [2009] EWCA Civ 362 (29 April 2009) and what the Court of Appeal say about the evaluation of suicide risk in that matter. This is not a case where we are striving to look for reasons to doubt the experts' views. We have attempted to approach this matter in a measured way. However, we have simply not found the account to be credible, thus undermining much of what has followed in terms of the medical opinion provided. We remind ourselves there is no room for emotional blackmail of the kind referred to by Sedley LJ. We are required to consider the authenticity of such claims with anxious scrutiny.
147. Following *J*, we are also entitled to take account of the Secretary of State's obligation to provide appropriately qualified escorts and of the available family support in India. We have regard to the Secretary of State's published guidance in relation to arranging removal in medical cases and what will happen if it transpires the appellant requires medical escorts due to any perceived risk. In our finding, the Secretary of State has a process in place to ensure that the appellant can be escorted if there are any serious concerns regarding his medical or health issues. He would also have familial support upon his initial return, as confirmed by his father.
148. It follows that, having regard to both article 3 claims, the broader picture, and the United Kingdom's obligations to ensure the appellant's safety during the return journey, the removal of the appellant to India would be proportionate.

The fourth issue: paragraph 276 ADE(1)(vi)

The respective submissions

149. It was advanced by Mr Eaton that the appellant qualified for leave to remain on the grounds that there would be very significant obstacles to him returning to India. He submitted that the appellant would suffer significant physical and/or mental suffering if returned. We were invited to take into account that the appellant was struggling with his sexuality. In relation to this, it was said to return him to India would likely exacerbate his mental health problems, given that he maintained that his family and community were not accepting of homosexuality.
150. We were referred to the Upper Tribunal decision in *MD (same-sex orientated males: risk) India CG* [2014] UKUT 65 (IAC), where it was submitted that while, as a general rule, homosexuality in India did not amount to persecution, homosexual males did suffer ill-treatment, extortion, harassment and discrimination from the police and the general populace. Mr Eaton maintained that the appellant's family did not know that he was gay and that he had a clear belief that they would behave violently towards him if they found out.
151. In relation to his private life and sexual orientation, we were also referred to the respondent's policy regarding very significant obstacles (Family Migration: Appendix FM section 1.0b family life (as a partner or parent) and private life: 10-year route version 4.0), this maintains:
- ...Very significant obstacles will exist where the applicant demonstrates that they would be unable to establish a private life in the country of return, where establishing a private life in the country of return would entail very serious hardship for the applicant.
- ...
- ...A very significant obstacle may arise where the applicant would be at real risk of prosecution or significant harassment or discrimination as a result of their sexual or political orientation or faith, or where the rights and freedoms would otherwise be so severely restricted as to affect their fundamental rights, and therefore their ability to establish a private life in that country.
- ...
- The decision-maker must consider the degree of difficulty that would be faced that is as a result of the applicant's faith, political or sexual orientation or gender identity based on the situation in practice in the country of return and not necessarily solely what is provided for in law. The applicant's previous experience of life in that country and any difficulties the applicant claims to have experienced as a result of their faith, political or sexual orientation or gender identity must be considered.
152. Conversely, it was advanced by Mr Kotas that the appellant did not face significant obstacles to reintegration. His sexuality would not preclude him from developing a private life in Chennai or another large city, pursuant to extant country guidance.

The law: 276ADE

153. Paragraph 276 ADE of the Immigration Rules provides:

Requirements to be met by an applicant for leave to remain on the grounds of private life

276ADE (1). The requirements to be met by an applicant for leave to remain on the grounds of private life in the UK are that at the date of application, the applicant:

1. (i) does not fall for refusal under any of the grounds in Section S-LTR 1.1 to S-LTR 2.2. and S-LTR.3.1. to S-LTR.4.5. in Appendix FM; and
2. (ii) ...
3. (iii) ...
4. (iv)
5. (v)
6. (vi) subject to sub-paragraph (2), is aged 18 years or above, has lived continuously in the UK for less than 20 years (discounting any period of imprisonment) but there would be very significant obstacles to the applicant's integration into the country to which he would have to go if required to leave the UK.

154. The test articulated by Sales LJ in *Kamara v Secretary of State for the Home Department* 2016 EWCA Civ 813 found the concept of integration to be a broad one:

'14... The idea of 'integration' calls for a broad evaluative judgement to be made as to whether the individual will be enough of an insider in terms of understanding how life in the society in that other country is carried on and a capacity to participate in it, so as to have a reasonable opportunity to be accepted there, to be able to operate on a day-to-day basis in that society and to build up within a reasonable time a variety of human relationships to give substance to the individual's private or family life'.

155. In *MD (same-sex oriented males: risk) India* CG [2014] UKUT 00065 (IAC) (*MD (same-sex oriented males: risk) India*) the court held, *inter alia* (adopting the headnote):

- c. Some persons who are, or are perceived to be, same-sex oriented males suffer ill treatment, extortion, harassment and discrimination from the police and the general populace; however, the prevalence of such incidents is not such, even when taken cumulatively, that there can be said in general to be a real risk of an openly same-sex oriented male suffering treatment which is persecutory or which would otherwise reach the threshold required for protection under the Refugee Convention, article 15(b) of the Qualification Directive, or article 3 ECHR.
- d. Same-sex orientation is seen socially, and within the close familial context, as being unacceptable in India. Circumstances for same sex orientated males are improving, but progress is slow.

- e. It would not, in general, be unreasonable or unduly harsh for an open same-sex oriented male (or a person who is perceived to be such), who is able to demonstrate a real risk in his home area because of his particular circumstances, to relocate internally to a major city within India.
- f. India has a large, robust and accessible LGBTI activist and support network, mainly to be found in the large cities.

Our findings: very significant obstacles

156. We have already found that that his medication and treatment is available in India. He has not sought any recent mental health care or medication in the UK. One of the earlier reports suggests social and community-based care would assist. We are satisfied that his family and friends in India would be able to offer such support. They have offered support to him in these proceedings and we have no proper reason to conclude that would not continue. His father, for example, has offered him accommodation for when he returns.
157. The appellant was awarded a masters degree in business administration from Staffordshire University in April 2014, which includes strategic management and leadership. This suggests a certain skillset. His level of education and interest in business is likely to serve him well in terms of employment prospects in India.
158. We are not satisfied that the appellant's family would behave violently towards him if they found out he was gay. There is little evidence for such an assertion. While there appears to be some form of expectation that he will marry, we are not prepared to speculate about whether he would be required to do so. We bear in mind that he has lived in the UK for almost 10 years and has not felt pressured to go back to India and get married. *Per MD (same-sex oriented males: risk) India*, we find that there is no real risk of persecutory treatment in India. He has been sexually active with men in India before his move to the UK and there is a large, robust and accessible LGBT support network should he require it.
159. We reject the suggestion that the appellant's or his family's financial position impact on the appellant's return to India. There is nothing out of the ordinary about owing money. Any debts that he may have place him in a no different position to most people. His aunt/landlady in her recent email expressed the view she was flexible in terms of the payments owed to her and his other UK borrowing (where there is evidence for the same) also appears flexible and will not impinge on his ability to integrate into life in his home country.
160. We are less than clear about his evidence in relation to the moneylender(s) in India, and on balance we are less than satisfied that the threats that he claims have been made are credible. We observe that when the appellant talks about his fears that he will be at risk from moneylenders, or that he has no means to pay back his debts, or that his parents are being harassed and threatened, or that he feels deeply embarrassed about having borrowed money from family and not being able to pay

this back, those concerns, individually or otherwise, do not appear to have impacted very much on his lifestyle in the UK. We have already expressed our reservations about the evidence concerning the debt.

161. The appellant is 'an insider' in terms of how life in India is carried on. He grew up there and had lived there all his life until his move to the UK. He speaks the language. The appellant worked there and has family there he can stay with. These are all relevant findings to the conclusion we come to which is that if there are obstacles, they are not significant, and certainly not very significant.
162. It follows, in making a broad evaluative judgement, as per *Kamara*, we are unable to find any very significant obstacles. While we acknowledge that there are likely to be some obstacles, including arranging employment and medical care, we did not see this as amounting to either a significant or a very significant obstacle for the reasons outlined. The obstacles we did identify were largely not dissimilar to any person relocating and could be generally overcome by a resourceful, intelligent individual (such as the appellant) with some planning. Their significance was considerably diluted as a result.

The fifth issue: Article 8 - private life

163. It was suggested that the appellant had established a meaningful private life in the UK, and the engagement with article 8 should be considered in the round with the proportionality of the whole decision. Therefore, it was submitted, the existence of obstacles to his private life existing elsewhere was a factor to be considered when assessing the correctness of the overall decision. It was contended that manifestly, the appellant's removal would disproportionately interfere with the appellant's private life developed in the UK; and viewed collectively, it was said that the appellant's physical and psychological condition; his sexuality and lack of meaningful support on return to India, amounted to compelling circumstances for the purposes of article 8.

The law - article 8

164. The assessment of the likely interference in terms of article 8 is not whether the appellant could establish a private life elsewhere, but rather whether his removal would interfere with the private life he currently enjoys. In so doing, we must have regard to the public interest considerations applicable in all cases, pursuant to Part 5A of the Nationality Immigration and Asylum Act 2002:

117B Article 8: public interest considerations applicable in all cases

- (1) The maintenance of effective immigration controls is in the public interest.

(2) It is in the public interest, and in particular in the interests of the economic well-being of the United Kingdom, that persons who seek to enter or remain in the United Kingdom are able to speak English, because persons who can speak English—

(a) are less of a burden on taxpayers, and

(b) are better able to integrate into society.

(3) It is in the public interest, and in particular in the interests of the economic well-being of the United Kingdom, that persons who seek to enter or remain in the United Kingdom are financially independent, because such persons—

(a) are not a burden on taxpayers, and

(b) are better able to integrate into society.

(4) Little weight should be given to—

(a) a private life, or

(b) a relationship formed with a qualifying partner,

that is established by a person at a time when the person is in the United Kingdom unlawfully.

(5) Little weight should be given to a private life established by a person at a time when the person's immigration status is precarious.

(6) In the case of a person who is not liable to deportation, the public interest does not require the person's removal where—

(a) the person has a genuine and subsisting parental relationship with a qualifying child, and

(b) it would not be reasonable to expect the child to leave the United Kingdom.

Our findings: Article 8

165. At page 639 of the bundle, the Home Office accepts that the appellant has established a private life in the United Kingdom. He has been studying here. We accept this and that he speaks English, has been largely financially independent and has flourished in the UK in terms of his social activity (reflected in the broad range of friends he has met, evidenced by the letters and statements in support and his bank account).

166. However, the respondent says, and we also accept, the appellant has only been granted leave in a temporary capacity and should always have intended to return to India, therefore interfering with his private life is a justifiable and proportionate course of action in pursuit of the legitimate aim of effective immigration control. Pursuant to 117B (5), little weight must therefore be given to that private life.

167. We find, on the appellant's own evidence, that he does not have a partner in the UK. He does not have children. His activities with other men are transient, and there is no proper reason to conclude that that element of his private life would be interfered with if he were to be removed.

168. While we accept that the appellant has medical needs, which until now have been served in the UK, we have already found, pursuant to his article 3 claim, that he would have access to the same types of medication and treatment in India. If he were not to return, in terms of the public interest, it is likely he will continue to be a significant financial burden on the resources of the NHS.

169. In terms of article 8 and proportionality, we note that in *SL (St Lucia) v Secretary of State for the Home Department* [2018] EWCA Civ 1894, the court held:

27: However, I am entirely unpersuaded that *Paposhvili* has any impact on the approach to article 8 claims. As I have described, it concerns the threshold of severity for article 3 claims; and, at least to an extent, as accepted in *AM (Zimbabwe)*, it appears to have altered the European test for such threshold. However, there is no reason in logic or practice why that should affect the threshold for, or otherwise the approach to, article 8 claims in which the relevant individual has a medical condition. As I have indicated and as *GS (India)* emphasises, article 8 claims have a different focus and are based upon entirely different criteria. In particular, article 8 is *not* article 3 with merely a lower threshold: it does not provide some sort of safety net where a medical case fails to satisfy the article 3 criteria. An absence of medical treatment in the country of return will not in itself engage article 8. The only relevance to article 8 of such an absence will be where that is an additional factor in the balance with other factors which themselves engage article 8 (see *MM (Zimbabwe)* at [23] per Sales LJ). Where an individual has a medical condition for which he has the benefit of treatment in this country, but such treatment may not be available in the country to which he may be removed, where (as here) article 3 is not engaged, then the position is as it was before *Paposhvili*, i.e. the fact that a person is receiving treatment here which is not available in the country of return may be a factor in the proportionality balancing exercise but that factor cannot by itself give rise to a breach of article 8. Indeed, it has been said that, in striking that balance, only the most compelling humanitarian considerations are likely to prevail over legitimate aims of immigration control (see *Razgar* at [59] per Baroness Hale).

170. The above reasoning is confirmed in *PF (Nigeria)* at para 20:

As I described in *SL (St Lucia)* at [22] and following, the relationship between the article 3 criteria and the article 8 criteria in the context of healthcare cases was considered by this court in *MM (Zimbabwe) v Secretary of State for the Home Department* [2012] EWCA Civ 279 ("*MM (Zimbabwe)*") and *GS (India) v Secretary of State for the Home Department* [2015] EWCA Civ 40; [2015] 1 WLR 3312 ("*GS (India)*"), which, in the words of Sales LJ in *AM (Zimbabwe)* at [6], "brought the test under article 3 and the approach under article 8 into close alignment" in the sense that, if a medical claim fails under article 3, it is unlikely to succeed under article 8.

171. As a result, we find that article 8 is not engaged within the Immigration Rules, that pursuant to 117B(1) the public interest in maintaining immigration control must prevail, and that the appellant's removal would be proportionate in all the circumstances outlined herein.
172. In considering article 8 outside of the Rules, Mr Eaton urged us to consider whether exceptional circumstances exist, namely whether there are other good grounds for granting this appellant leave to remain.
173. The appellant advances that he has a meaningful private life in the UK. In the bundle there is evidence of him attending an Islamic resource centre on a regular basis for Friday prayer, volunteering and statements from friends who he has met, (some of whom clearly know him better than others).
174. While we accept that the appellant has integrated socially into UK society in the last 10 years, he has made friends, found work and assisted others, we see no reason why such a life cannot be replicated in India where he grew up. He was educated in India and he will still have connections there. But for the advanced kidney disease that led to his operation, it is more likely than not that he would have returned to India.
175. We can find nothing exceptional in the appellant's case. In our finding, he would be able to keep in contact with his UK friends, including his kidney donor, through modern methods of communication, like the Internet. He can continue to worship and help others less fortunate in India. While the decision to remove him might cause a degree of inconvenience and disappointment, this was not decisive from the viewpoint of article 8.
176. Whilst Mr Eaton submits that the removal of the appellant would not be proportionate, following *R (Razgar) v Secretary of State for the Home Department* [2004] UKHL 27, we disagree for the reasons already given. While we would accept that the threshold assessment of whether there is likely to be any interference with article 8 is not a high one, we have struggled to find any proper reason for article 8 being engaged in the current matter. In our view, any interference is in accordance with the law and proportionate to the legitimate public end sought.
177. Even through the lens of considering this matter in the round and taking into account the myriad of objections raised to the appellant's return, as we have done at each step of the process; and having the proportionality of the decision as a whole in mind, we do not find that any of his personal circumstances are 'exceptional' and certainly not 'truly exceptional'.

Conclusion

178. We are not satisfied that the appellant has proved, to the lower standard, that he would be at risk either on article 3 medical grounds or that there is a serious suicide risk engaging article 3, nor that, on balance, 276ADE or article 8 ECHR are engaged, such that to return the appellant would be disproportionate.

Notice of Decision

For the above reasons, we dismiss the appeal on all grounds.

Signed

A handwritten signature in black ink, appearing to read 'J. Sutherland Williams', written over a horizontal line.

Date 1 November 2019

Deputy Upper Tribunal Judge Sutherland Williams
Upper Tribunal Judge Dawson