



Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: HU/00819/2019

THE IMMIGRATION ACTS

Heard at Field House
On 27 July 2021

Decision & Reasons Promulgated
On 19 August 2021

Before

UPPER TRIBUNAL JUDGE PITT

Between

M A H

By his Litigation Friend T C
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Ms J Fisher, Counsel, instructed by Duncan Lewis & Co Solicitors
For the Respondent: Mr C Avery, Senior Home Office Presenting Officer

DECISION AND REASONS

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

1. 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 their 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.

2. This decision is a remaking of MAH's appeal against the respondent's decision dated 9 May 2018 to deport him. The appellant brings his appeal under Articles 3 and 8 of the European Convention on Human Rights (ECHR).

Background

3. The appellant is a citizen of Morocco, born on 20 May 1966.
4. The appellant maintains that he came to the UK on 17 February 1985 with a visit visa. The respondent maintains that there is no record of any involvement with the immigration authorities until 2001 but accepts that a criminal conviction in 1986 indicates that the appellant was present in the UK at that time. Nothing before me suggested other than that the appellant has been in the UK since at least 1986 and the respondent did not argue otherwise in the proceedings before me.
5. At some point, the appellant formed a relationship with a British national, married and had two children. However, his relationship with his family appears to have foundered during the 1990s and he has not had contact with them for many years. There is a reference in the appellant's mental health records to involvement with mental health services in 1995 but no details of this.
6. It is undisputed that the appellant was granted indefinite leave to remain (ILR) in 2001. The basis for that grant is unclear. Ms Fisher maintained that it could be inferred that the grant of ILR in 2001 showed that the appellant must have had legal status earlier than that, possibly continuous legal status since 1985. Without more evidence, I did not find that this was a conclusion that I could draw and proceeded on the basis of the history set out here.
7. The psychiatric evidence provided, considered in more detail below, sets out that the appellant was unwell and homeless for extensive periods after 2001. Details of the appellant's contact with St Mungo's, a homelessness charity, are recorded in paragraph 86 of the report of Dr Bargiela and indicate that the appellant was involved sporadically with mental health services, including detentions in a mental health hospital in 2007 and 2008.
8. The appellant also amassed a very extensive criminal history, albeit of relatively minor non-custodial offences. Between 1986 and 2017 he received 73 convictions for 124 offences, including 5 offences against the person, 2 offences against property, 54 theft and kindred offences, 10 public disorder offences, 31 offences relating to police, courts and prisons and 20 drug related offences. It is not contentious that this forensic history is closely associated with the appellant's mental disorder.
9. The respondent was aware of the appellant's convictions but in 2007, 2010, 2013, 2016 and on two occasions in 2017 decided not to pursue deportation action. However, following convictions on 16 October 2017, 30 October 2017 and 20 November 2017 for breach of an Anti-Social Behaviour Order (ASBO), the last of which led to a sentence

of 14 days' imprisonment, the respondent commenced deportation action. The appellant was served with a decision to deport on 28 November 2017 made under section 5(1) of the Immigration Act 1971, his deportation being deemed to be conducive to the public good. In a decision dated 9 May 2018, the respondent refused the appellant's human rights claim.

10. After the appellant completed his 14-day prison sentence in November 2017, he was kept in immigration detention. He was still in detention on 17 May 2018 when he was served with the decision dated 9 May 2018 refusing his human rights claim. The appellant did not appeal at that time.
11. In August 2018 the appellant was still in prison and was encountered in detention by Duncan Lewis Solicitors. Acting *pro bono*, on 12 September 2018 the legal representatives attempted to lodge an out of time appeal. They applied for legal aid funding to pay the fee for the appeal but discovered that the appellant had funds held by Social Services under an appointeeship which precluded him from being granted public funding. Despite extensions of time to allow for the fee to be paid being granted by the First-tier Tribunal, the legal representatives were unable to comply and the appeal was closed on 8 November 2018.
12. By December 2018, however, the appellant had instructed his legal representatives privately and on 7 January 2019 they submitted a second out of time appeal against the decision of 9 May 2018. The First-tier Tribunal accepted that appeal as in time in a decision dated 19 February 2019. It is that appeal that continues here.
13. On 6 March 2019 the appellant was discharged from detention. He was discharged to no fixed abode, became street homeless and did not remain in contact with his legal representatives.
14. The appellant's appeal was listed for a Case Management Review (CMR) in the First-tier Tribunal on 26 March 2019. His legal representatives attempted to have the CMR adjourned as they were not in contact with the appellant and not in funds to represent him. The CMR proceeded with a representative from the legal representatives attending *pro bono*. The First-tier Tribunal declined to adjourn the substantive hearing which was listed for 16 May 2019. The legal representatives came off the record on 7 May 2019 where they remained without instructions from the appellant.
15. The appeal came before First-tier Tribunal on 16 May 2019. There was no appearance by or for the appellant. The First-tier Tribunal judge proceeded with the hearing, finding that the appellant "has not provided any explanation for his nonattendance". The appeal was dismissed in a decision dated 31 May 2019.
16. As set out in a letter dated 6 June 2019 from Duncan Lewis Solicitors to the First-tier Tribunal, on 17 May 2019 they were approached by the Outreach Team at St Mungo's who informed them that the appellant had been found sleeping rough in Leicester Square. The legal representatives made contact with the appellant and went back on record as acting on 31 May 2019. They requested a copy of the First-tier Tribunal decision in order to prepare an out-of-time appeal and lodged the appeal on 23

August 2019. The application was accepted as in-time by the First-tier Tribunal and permission to appeal to the Upper Tribunal granted on 4 October 2019.

17. By the time that permission was granted, the legal representatives were having difficulty taking instructions from the appellant and concerns arose over his capacity. The legal representatives obtained a Certificate of Suitability for a Litigation Friend dated 31 October 2019. The Certificate indicated that the Official Solicitor had consented to act for the appellant on the basis that he was a protected party. By the time of a CMR in the Upper Tribunal on 3 December 2019, however, it became apparent that, albeit the appellant remained a protected party because of his lack of capacity, the Official Solicitor was not able to represent him.
18. The legal representatives, with the assistance of an organisation called Migrants Organise, found a Litigation Friend for the appellant, Ms ten Caten. At a further CMR hearing on 20 January 2020 proceedings were further delayed, however. Firstly, the legal representatives had not finalised funding for the Litigation Friend. Secondly, the appellant was still homeless and was unwell, having been without medication for his mental disorder since March 2019.
19. In anticipation of funding for the Litigation Friend being available from HMCTS, an error of law hearing was listed for April 2020. The Covid-19 pandemic then intervened and the hearing was adjourned.
20. On 13 August 2020 the Litigation Friend provided a Certificate of Suitability confirming that she was able to represent the appellant. An error of law hearing was listed for 20 January 2021. As set out in my error of law decision issued on 21 January 2021, at that hearing the respondent conceded error of law in the decision of First-tier Tribunal. The re-making of the appeal was retained in the Upper Tribunal following the presumption set out in paragraph 7 of Part 3 of the Senior President's Practice Statement dated 11 June 2018.
21. At a CMR on 14 April 2021 the respondent consented to the grounds of appeal being extended to include Article 3 ECHR and the Upper Tribunal agreed to this variation of the grounds. Both parties were granted permission to adduce further medical evidence.
22. A hearing for the remaking of the appeal was listed for 20 July 2021. For that hearing, the respondent provided a position paper dated 7 July 2021 and materials on medical treatment available in Morocco. The appellant provided a consolidated bundle (CB) comprising 360 pages and a supplementary bundle (SB) comprising 51 pages.

MAH's Medical Issues

23. The appellant's psychiatric history is set out in a number of reports from the mental health professionals who have treated him whilst he has been in the UK. The materials included reports from Dr Bargiela dated 20 September 2019, Dr Rahman dated 3 April 2021, Dr Hall dated 31 March 2021 and Ms Siddal dated 26 May 2021. The reports are all closely consistent and it was not disputed before me that they set

out an accurate assessment of the appellant's mental disorder and treatment needs. As it is the most detailed, the information set out below is taken from the report of Dr Rahman dated 3 April 2021 unless another source is specified.

24. Dr Rahman indicates that limited psychiatric notes are available prior to 2010. The limited materials referred to admissions to hospital in 1995, 2005 and 2007. There is an a reference to an admission in 1983 which remains unexplained, the appellant not claiming to have been in the UK at that time. By August 2010 the appellant had been diagnosed with paranoid schizophrenia and was being treated with a zuclopenthixol decanoate depot injection every 3 weeks. The reports indicated that from 2010 to 2017 the appellant was under the care of a number of community teams, including the Joint Homelessness Team and the Community Rehabilitation Team. The records showed a persistent history of significant problems with selfcare, minimal engagement and ongoing concerns about drug use. It was also noted that the appellant had received a number of injuries related to his involvement with drugs including a fractured jaw and in 2015 sustained bilateral hip fractures after being run over.
25. In 2017 the appellant was living in supported accommodation, subject to an ASBO related to begging which he repeatedly breached. As above, the appellant was then imprisoned for 2 weeks in November 2017 following a further breach of the ASBO. He was then kept in immigration detention until 6 March 2019. He was treated by prison mental health services with whom the Community Rehabilitation Team liaised. Community services were not informed of the appellant's release from prison, however, and, as above, he was released to no fixed abode on 6 March 2019.
26. The reports from the mental health professionals and from St Thomas Hospital showed that after his release from prison in March 2019, the appellant suffered a number of physical and mental health crises. After his release from prison, the appellant was homeless. He was encountered by outreach workers from St Mungo's in May 2019. He resumed some contact with his legal representatives that month and the materials also showed that he was referred to mental health services but was not able to engage. He remained homeless and his mental disorder was untreated. Ms Sibbald, the appellant's Care Coordinator, describes this period in paragraph 8 of her report dated 26 May 2021.

"He requires support with engaging health and psychiatric services. Since being released from his last prison sentence in March 2020, he resumed rough sleeping. He did not even remember to go to the day centre that could have supported him, he was unable to keep appointments, attend day centres, or engage with homeless outreach workers and with the Joint Homelessness Team. His mental health unravelled very quickly, he was living a chaotic life, was destitute and sleeping rough - he was not even able to maintain a regular sleep site."

The reference in the second sentence should be to March 2019, not March 2020.

27. This period of untreated mental illness and homelessness led to a physical health crisis. On 21 January 2020 the appellant was admitted to St Thomas Hospital with hyperthermia and hypoxia, thought to have been precipitated by a pneumonia. On

admission to hospital, he had a heart attack. A letter dated 14 May 2021 from Dr Webb, Consultant Cardiologist in the Cardiology Department at St Thomas Hospital, confirmed that the appellant's heart stopped during this incident and he was resuscitated after two cycles of cardiopulmonary resuscitation (CPR) and taken to the intensive care unit. Dr Webb set out that the appellant experienced a "profound cardiovascular insult". She indicated that the cause of the cardiac arrest was "most likely due to the significant hyperthermia with a chest infection, on the background of iron deficiency, anaemia and nutritional depletion." The letter includes Dr Webb's stark statement that "if he had not received the care he did, he would not have survived."

28. Dr Webb also indicated that tests conducted after the appellant had been resuscitated indicated that the appellant had a "moderate to severe" impairment in his heart function. The appellant was put on daily medication to support his heart. He was prescribed eplerenone 25 mg, furosemide 40 mg, bisoprolol 7.5 mg, and ramipril 5 mg. Following a period of consistent medication, the impairment to the appellant's heart function had reduced to "mild" impairment by March 2021. Dr Webb confirmed that the appellant required ongoing medication as without it his heart function would deteriorate again.
29. On admission to St Thomas Hospital in January 2020, the appellant also presented as significantly mentally unwell, expressing tactile hallucinations, persecutory beliefs and being significantly self-neglecting. His presentation was consistent with the records held by mental health services and he was detained under s.2 of the MHA. He absconded from the hospital after the section was made but returned and was transferred to a mental health unit at the Gordon Hospital on 19 February 2020.
30. The appellant then absconded again and this led to the section being discharged on 23 March 2020 as he could not be located. He became homeless again and on 7 October 2020 was arrested by police having reportedly spat in the face of a member of the public. He was again assessed under the MHA and again detained under s.2 of the MHA, initially being detained at HMP Wandsworth and then being transferred to a mental health ward at St Charles Hospital on 14 October 2020. He presented as acutely unwell, remaining manic and labile throughout October 2020.
31. As a result of the seriousness of his presentation, the appellant was transferred to a Psychiatric Intensive Care Unit (PICU) at St Charles Hospital on 6 November 2020. Dr Rahman was his Responsible Clinician whilst he was in the PICU. Such was the extent of the appellant's relapse that he continued to present as extremely unwell on the PICU even after depot antipsychotic medication was introduced, smearing faeces across his bedroom wall on 8 November 2020, being involved in a fight with another patient on 9 November 2020 which led to police being called, expressing grandiose delusional ideas and fluctuating mood. It was during this period of detention on the PICU that his diagnosis was amended to that of a schizoaffective disorder. As a result of his continued serious relapse, the dosage of his zuclopenthixol decanoate depot was increased to 300 mg every 2 weeks. He continued to be unwell, spitting unprovoked at his Consultant Psychiatrist on 18 November 2020. On 19 November 2020 he smashed a phone and rapid tranquilisation medication was required. In

view of his labile mood his mood stabiliser medication, sodium valproate was also increased.

32. On 2 December 2020 the appellant complained of a sharp chest pain and in light of his cardiac history he was taken to A & E at St Mary's Hospital for an urgent review. He absconded from St Mary's whilst being investigated although he later returned voluntarily and was transferred back to the PICU.
33. The appellant was transferred to a general mental health ward on 5 December 2020 as his mental state and behaviour had moderated sufficiently. On 7 January 2021 he was given leave under s.17 of the MHA but did not return to the ward. On 8 January 2021 he was admitted to St Mary's Hospital having suffered a collapse. He was diagnosed as experiencing an opioid overdose and pneumonia. On admission he had a reduced respiratory rate. He was provided with medication and cleared for discharge back to St Charles Hospital.
34. Once back at St Charles, a care plan leading to discharge to the community was prepared which included a Community Treatment Order (CTO) made under s. 17A of the MHA. The conditions of the CTO included the appellant accepting his depot antipsychotic medication and living in 24-hour supported accommodation. If the conditions of the CTO were not met, the community Responsible Clinician had the power to recall the appellant to hospital and revoke the CTO leading to a further period of detention in hospital. The care plan, intended to assist the appellant to remain stable in the community, included a keyworker to see him daily, a Care Coordinator from a community team, support from drug and alcohol services and a neurocognitive assessment due to what were considered to be "likely cognitive problems".
35. The appellant was discharged from hospital on the CTO on 15 January 2021 to the King George Hostel and continues to live there now.
36. On discharge, the appellant's care was transferred to a Responsible Clinician in the community, Dr Bellew. Dr Rahman's report sets out details of Dr Bellew's review of the appellant on 4 February 2021. After the appellant was discharged to King George Hostel, concerns arose as he did not return some nights and was noted to be drowsy. He denied illicit drug use but a urine drug screen conducted on 28 January 2021 was positive for illicit drugs. The appellant told Dr Bellew that he wanted to be "clean" which was thought to be a reference to his drug use. He was advised of the danger of his illicit drug use given his heart condition. The appellant did not think that he had a mental disorder and could not identify any benefit from his depot medication. He was, at best, ambivalent about the usefulness of his medication and whether he would continue with it were he not obliged to do so by the CTO. His history did not show that he actively refused or resisted medication, however, and he was found to be compliant, albeit without capacity.
37. Dr Bellew confirmed that the appellant continues to require daily support to supervise his mental and physical health and his medication. Ongoing ECG monitoring was stated to be "particularly important given his cardiac problems" and

was to be repeated in 6 weeks in the event of there being no cardiology review within that period. Dr Hall, the appellant's current community Responsible Clinician provided a similar professional view to those of Dr Rahman and Dr Bellew in her report dated 31 March 2021.

38. The current situation is that the appellant's schizoaffective disorder is being treated with an antipsychotic in the form of a depot injection of zuclopenthixol decanoate 300 mg once every 2 weeks and an oral mood stabiliser of sodium valproate 2g once daily. As Dr Bargiela notes in her report, depot medication is used where someone is "unable or unwilling to take daily medication, normally because they either lack capacity or lead a chaotic lifestyle".
39. In addition to pharmacological treatment the appellant is being treated with a high level of specialist psychiatric input. In paragraph 86 of his report Dr Rahman sets out:

"Mr [MAH]'s substantial care needs are currently met through an assertive mental health and social care team (Joint Homelessness Team). The team works with third sector suppliers of 24 hour supported accommodation to [MAH] and have linked him with community drug services. He receives daily visits by a carer to ensure compliance with oral medications.

Dr Rahman confirms in paragraph 21 of his report that, in addition to daily visits from a key worker to supervise medication compliance and support the appellant with his basic tasks of daily living such as feeding himself, the appellant has regular meetings with his Care Coordinator, Ms Sibbald, and is reviewed by his community Responsible Clinician every few months to monitor his mental state and review his medication.

40. In paragraph 87 of his report Dr Rahman states:

"Mr [MAH]'s mental health needs are managed under Section 17A (CTO) in order to ensure compliance with depot antipsychotic medication, without which he is highly likely to remain compliant with treatment and likely to relapse in his mental health."

This sentence must have been intended to state that it is "highly unlikely" that the appellant will be compliant with treatment without the support of the CTO as it otherwise makes no sense when read with the remainder of Dr Rahman's report and the other psychiatric evidence; see paragraph 96 set out below, for example.

41. In paragraph 95 Dr Rahman states:

"In my clinical opinion, the lack of psychotropic treatment on Mr [MAH]'s mental state would have been significant and would highly likely lead to a deterioration in his mental health. Patients with severe, chronic and longstanding psychotic illness, as in Mr [MAH]'s case, usually demonstrate a gradual insidious and significant decline in their mental state if they are not administered regular psychotropic medication.

In my opinion, an important cause of Mr [MAH]'s mental health relapse in October 2020 was secondary to the lack of psychotropic treatment alongside the lack of community mental health support and use of recreational substances following his release from Prison (sic)."

42. Dr Rahman continues in paragraph 96:

“Mr [MAH] requires substantial care for his chronic mental illness. His complex mental health needs are currently met through an assertive mental health and social care team, the Joint Homelessness Team. The team monitors his mental state in compliance with treatment, works with third sector suppliers of 24 hour supported accommodation, liaises with drug services to provide Mr [MAH] with support with his drug use and arranges daily visits by a carer to ensure compliance with oral medicines. Mr [MAH]’s mental health needs require him to be managed under Section 17A (CTO) in order to ensure compliance with mental health treatment without which he will highly likely relapse in his mental state.

Mr [MAH] also suffers from severe, complex physical health issues. His physical health requires ongoing monitoring by his GP and secondary care services. In view of the cardiometabolic side effect profile of antipsychotic medications, it is essential that Mr [MAH]’s antipsychotic medication is carefully monitored by his GP with regular blood tests and other investigations to ensure the cardiac safety of the prescribed treatment”.

43. In paragraph 98 Dr Rahman sets out:

“Given his complex mental health needs, current financial status and lack of social support in Morocco, I do not believe Mr [MAH] will be able to seek the required medical and community support that he requires if his mental health deteriorates in Morocco. This will put him at high risk of suffering a relapse of his mental illness and further deterioration of his physical health”

and continues in paragraph 100:

“If Mr [MAH] does not receive medical treatment for his mental health, he is highly likely to suffers (sic) a relapse of his Schizoaffective Disorder that will require treatment in a hospital setting. When suffering a relapse, Mr [MAH] poses a significant risk to his own health and safety, the safety of others and increase (sic) his risk of vulnerability and exploitation. If Mr [MAH] does not receive medical treatment for his physical health, he is highly likely to suffer a serious deterioration in his physical health, including the risk of death. He suffers from a significant physical health illness and has suffered a cardiac arrest in the past. Mr [MAH] suffers from heart failure with a low ejection fraction that will deteriorate further and cause serious physical health complications if he does not receive appropriate medical treatment and support.”

44. Dr Rahman’s concerns for the appellant’s mental and physical health if he is not able to obtain the high level of care he currently receives were supported by appellant’s Care Coordinator, Ms Sibbald. Ms Sibbald is an Approved Mental Health Professional (AMHP) working in the Westminster Joint Homelessness Team. Her report dated 26 May 2021 confirms the long history of a serious psychotic illness, history of substance abuse and of homelessness. In paragraph 4 Ms Sibbald indicates that the appellant:

“... has a history of poor engagement with mental health and substance use services and of self-neglect, he requires a supportive environment which provides 24 hour staffing. He also needs an assertive approach from mental health services.”

45. Ms Sibbald notes that the CTO was put in place because there were concerns “that he may not continue with his medication” or engage with the team and that “he may need to be at short notice for more treatment”. In paragraph 7 Ms Sibbald confirms the “high level of support” provided by the appellant’s current accommodation. She confirms that in addition to her support, the appellant has a psychiatric nurse who assists him with his depot medication and a keyworker who attends daily to ensure, amongst other matters, that he takes his medication, in particular his heart medication.

46. In paragraph 9 Ms Sibbald continues:

“Mr [MAH] is a vulnerable man who is unable to manage his life in the community without a high degree of support and prompting. In terms of taking his medication – he requires daily supervision from a carer. His keyworker also prompts him to eat when he forgets to do so and supports him to manage his personal care and environment; she also organises and reminds him to attend appointments with regards to his physical and mental health and, indeed, attends these with him. I am not sure how [MAH] would cope without the current support he is getting; I think he would struggle without financial support and prompting and both his medical and physical health would deteriorate.”

47. Ms Sibbald goes on to set out other aspects of the appellant’s vulnerability in the absence of a high support psychiatric care in paragraph 11 of her report:

“Mr [MAH] is very prone to exploitation. He gets very confused at times and finds it hard to keep focus. It is easy to persuade him to depart with his money; people pray on him. When he had Leave to Remain he was eligible to claim welfare benefits and did so. Mr [MAH] was also then – under the care of Community Mental Health Services and his finances were subject to an appointeeship managed by Westminster Client affairs – because he had no capacity to manage his benefits and they wanted to ensure that his rent was paid and that he was not exploited by drug dealers and gave them all the money as soon as his benefits were paid. This remains the case today. I refer to exhibit EX3 again, which confirms that in 2012 Mr [MAH] was assessed as needing support with his housing and was under an appointeeship because he was being exploited by others and was unable to manage his own finances.”

Exhibit EX3 is a care plan from 2012.

48. Ms Sibbald states in paragraph 12:

“Without intensive and structured support from services such as ours, Mr [MAH] would be unable to maintain accommodation or manage his finances and would also be unable to manage his mental and physical health. Given that he has a cardiac condition, his physical health would be at risk. I recall that in January 2020, when Mr [MAH] was admitted to St Thomas, he very nearly died of a heart failure.”

49. The medical evidence sets out a consistent and unambiguous picture of the appellant’s longstanding diagnosis of a chronic, remitting and relapsing mental disorder, complicated by illicit drug abuse. When untreated, he becomes floridly unwell and psychotic to the extent of requiring admission to hospital under section, including periods in a PICU. In relapse he is unable to manage the most basic rudiments of day-to-day life such as feeding himself, unable to contact or engage

with mental health services and has become destitute for extensive periods and extremely vulnerable to harm and exploitation. Even after receiving consistent and intensive pharmacological and therapeutic support over the last 10 months, he remains “a vulnerable man who is unable to manage his life in the community without a high degree of support and prompting” and remains “very prone to exploitation”. As a result, he continues to require 24-hour supported accommodation, close supervision and monitoring in order to ensure compliance with his medication and ensure that his basic daily needs, such as nutrition, are met and that he engages with drug therapy services and remains safe. He requires particularly close supervision for the daily medication for his heart condition without which he would be vulnerable to another crisis such as that which occurred in January 2020. His physical health also requires ongoing monitoring by his GP and secondary care services.

Medical Treatment in Morocco

50. The respondent did not dispute the evidence on the appellant’s diagnosis and treatment needs. Her position was that sufficient treatment would be available in Morocco such that the appellant would not face “a serious, rapid and irreversible decline in health resulting in intense suffering” or “a significant reduction in life expectancy”.
51. In support of her argument, the respondent relied on materials at pages 338 to 360 of CB and further materials enclosed with her written submissions dated 7 July 2021.
52. The first document relied on by the respondent is an article from “European Psychiatry” from April 2017 entitled “Mental health and human rights in Morocco: The urgent need for a new policy”. The article indicates:

“Structures are insufficient and inadequate in terms of geographical distribution, architecture and equipment. There is a big shortage of medical and paramedical staff and little interest is given to vulnerable groups. Nevertheless, huge improvements have also been achieved through time with mental health issues becoming a cornerstone of the ministerial programme, the involvement of the NGOs, the construction of new facilities, the implementation of an information gathering system and the presence of a substance use policy.”
53. The respondent also provided an article from “Morocco World News” dated 4 August 2020 describing a government proposal for social security cover to be extended to all Moroccans. The intention is for the planning stage of the project to be completed by the beginning of 2022 after which there will be “gradual implementation”. The article indicates that the plan “is set to include all Moroccans in the Compulsory Health Insurance (AMO) programme.”
54. The respondent also provided a Response to an Information Request (RIR) dated 19 February 2020 on the availability of methadone treatment programmes in Morocco. The response indicates that there has been a drug abuse and methadone substitution treatment programme in Morocco since at least 2010 in at least one institution and that “addiction treatment units are operating in several rehabilitation centres in the

nine cities of Casablanca, Rabat, Tangier, Tetouan, Marrakech, Oujda, Agadir, Fez and Meknes.” It is reported that “27,620 drug addicts have been treated in rehabilitation centres and 1,629 others given methadone maintenance treatment.

55. The respondent also provided a RIR entitled “Morocco: Treatment for mental health” dated 1 November 2018. Commenting on the general healthcare system in paragraph 2.1.1, the RIR states that “the Moroccan health system is generally well developed and well run in the cities, while the countryside is less well equipped”. There are also private hospitals offering high-quality services in cities but outside the cities facilities are “basic and oldfashioned”.
56. In paragraph 2.2.2, again referring to general healthcare, the RIR refers to primary healthcare centres providing access for free and being located in all Moroccan districts. Only a national ID is needed to obtain treatment from a primary healthcare centre. They offer “free emergency medical treatment that include tests, medicine, ambulance, nurses or an overnight stay in public hospitals”. The same paragraph indicates that:

“There are no free consultations in the public hospitals. Patients have to pay between MAD [Moroccan dirham] 100 and MAD 150 for a consultation by a generalist and between MAD 200 and MAD 250 for a consultation by a specialist. Only the emergency treatments are free”.
57. The RIR goes on in to address mental health provision, referring in paragraph 3.1.1 to a MedCOI response dated 17 May 2017. MedCOI is a project funded by the European Refugee Fund in assist European Union members to obtain medical country of origin information. The MedCOI response dated 17 May 2017 states that short term psychiatric clinical treatment is available from a psychiatrist in public facilities but outpatient treatment only in private facilities. In-patient treatment by a psychologist and forced admittance is available in public facilities. There is a reference to psychiatric treatment by way of assisted living/care at home by a psychiatric nurse in the public system. This is stated to be “Partly available; Only with authorisation: Hospital psychiatrist”. Psychiatric long-term clinical treatment for chronic psychotic patients is stated to be available in public facilities.
58. The November 2018 RIR goes on to indicate that the 2017 MedCoi response “noted that states: psychiatric treatment in the form of sheltered housing (e.g. for chronic psychotic patients) **was not available** (their emphasis)”.
59. In her position statement dated 7 July 2021, the respondent sought to rely on a further RIR dated 18 June 2021 entitled “Morocco: medical treatment for paranoid schizophrenia and heart failure” and a report entitled “The Economy of Mental Health: Inequalities in Access to Care in Morocco” by Dr Charlotte Hajer which would appear to be from 2015.
60. The RIR dated 18 June 2021 was obtained specifically for MAH. In paragraph 1.1.1 it confirms the availability of some psychiatric and psychology treatment in public health facilities, specifying that such treatment is available in particular hospital in Sale. The same facility is stated in paragraph 1.2.1 to have oral antipsychotic

medication available in the form of olanzapine, aripiprazole, paliperidone, lorazepam and zolpidem. In paragraph 1.2.2 the RIR indicates that in-patient, outpatient and follow up treatment by a psychiatrist and a psychologist are available at the public hospital in Sale and that in-patient treatment by a psychologist was also available in Rabat.

61. In paragraph 1.3.1 the response sets out that a RIR dated 4 February 2020 indicated that fluphenazine decanoate and haloperidol decanoate depot medication were available from private facilities in Morocco.
62. Paragraph 1.4.1 of the June 2021 RIR also refers to in-patient, outpatient, follow up by a cardiologist and surgery, including cardiac surgery and heart valve surgery being carried out in public facilities in Morocco.
63. The respondent also provided the report from Dr Hajer which was undated but appeared from the contents to be from 2015. Dr Hajer indicates that “a majority of Moroccans who suffer from mental illness still do not receive adequate care – and many never get to see a psychiatrist at all”. She refers to “a lack of availability and a marked inequality of access to the resources that do exist”. She states that “good mental healthcare in Morocco generally remains difficult to obtain for any but those who belong to the country’s upper socio-economic classes”.
64. Dr Hajer considers the distribution of healthcare facilities to be “sparse and uneven”. She estimates the total number of practicing psychiatrists in Morocco to be 350 “which translates into a ratio of about one specialist per 100,000 people”. She indicates that some of these psychiatrists run private practices while others are connected to 27 public institutions for mental healthcare which comprise a combination of psychiatric wards within general hospitals, specialised mental health facilities, and psychiatric teaching hospitals.
65. As regards the number of beds available in mental health facilities, Dr Hajer states:

“In efforts, once again, to decentralise the nation’s network of mental health resources and favour regional community treatment over large urban institutions, the number of beds available at each of these institutions has been deliberately limited or even scaled back”.

She goes on to state that the government has not had the resources to meet this bed closure programme with an expansion of mental healthcare facilities across the country. As a result, the 27 public institutions provided no more than approximately 1,900 beds for mental healthcare nationwide which amounted to less than 1 per 17,000 people.

66. Dr Hajer also refers to limitations on the treatment available “by virtue of Morocco’s national health insurance law”. She explains that there is a basic universal healthcare system, the *Assurance de Maladie Obligatoire* (AMO) which covers anyone employed in the public or private sector. There is also a supplementary system, the *Regime d’Assistance Medicale aux personnes Economiquement Demunies* (RAMED) which is

“available for anyone who cannot pay for healthcare on his or her own and is ineligible for the AMO”. Dr Hajer indicates that:

“Mental healthcare, however is included neither in the AMO nor in the RAMED. Coverage for psychiatric services would require payment into a more expansive – and therefore more expensive – insurance policy, which is out of financial reach for many of those most in need of assistance. Once again, a tragic paradox ensues: mental healthcare is more costly for those who are less able to pay.”

Dr Hajer’s view is that those with limited socioeconomic resources are “at risk of receiving insufficient treatment”. She also identifies that psychiatric problems are commonly stigmatised in Morocco.

67. In her conclusion Dr Hajer states that the “problem of unequal access to mental healthcare is particularly acute”. She refers to efforts being made to improve “both the quality and quantity of psychiatric resources in Morocco but concludes that ‘further work is necessary to truly render mental healthcare available to all who need it’. Dr Hajer’s ends her report with her view that:

“Only when psychiatric services are incorporated into both AMO and RAMED coverage, and when hospital payments are administratively decoupled from one’s designation to a particular ward, will mental healthcare truly be available to all.”

68. The appellant provided a country expert report from Ms Katja Zvan Elliott. Ms Elliott is an academic specialising in Moroccan gender, family and societal relationships, human rights and people’s access to those rights, as well as political and legal reforms since 2006. She indicates in paragraph 3 of her report that her current research is “with low income people about their experiences with ‘being poor’ and the issue of lack of access to quality healthcare services.
69. Mr Avery suggested that less weight should be placed on Ms Elliott’s report as her expertise is not in the field of mental health provision in Morocco. I saw some force in Mr Avery’s submission but only to a somewhat limited extent. Ms Elliott does have experience and expertise regarding aspects of the healthcare system in Morocco, including the funding systems. Her report makes clear that much of what she says on mental health care is taken from other sources to which she makes specific reference, those sources including the report from Dr Hajer which was also provided by the respondent. She also relies on a report from Morocco’s National Human Rights Council (CNDH) entitled “Mental Health and Human Rights: Urgent Need for New Policy” issued in December 2012 and a report from Dr Stefania Pandolfo from 2018 entitled “Knot of the Soul: Madness, Psychoanalysis, Islam”. Nothing about those sources suggested that they were not reliable or without the requisite expertise. There were no particularised challenges to the contents of Ms Elliott’s report and it did not appear to me that the information she set out on mental health treatment diverged in any material way from the other evidence before me, including that relied upon by the respondent.
70. In paragraph 6, like Dr Hajer, Ms Elliott indicates that the Moroccan government operates the RAMED system but that lower socioeconomic groups still find it difficult to benefit from this:

“However, many women I talk to in the Listening Centre as well as my current interviewees confirmed that they either have not applied for the RAMEd card or have not renewed it. Cards are only valid for three years after which individuals have to resupply all of the required documents, which necessitate knowledge of what these documents are, photos of oneself and their family members, and a number of Certificates issued by different administrative buildings. To obtain these Certificates, people have to know or be able to ask about the procedure, they need money to travel from their homes to the municipalities and once there, between different administrative buildings, time to do that but also IDs.”

71. In paragraph 7 Ms Elliott sets out that:

“All of my interviewees also complain that in public hospitals the medical staff would not admit them or give them information about the services they provide unless they paid a “fee”, i.e. give them a bribe.”

72. From paragraph 7 to 17 Ms Elliott sets out a commentary on psychiatric care in Morocco, placing heavy reliance the report from Dr Hajer, the CNDH report and Dr Pandolfo’s report. The CNDH Report states that a notable feature of mental health provision in Morocco is the “poor quality of the medical and non-medical services offered to those receiving psychiatric care and the living conditions to which they are subjected during hospitalisation”. The CNDH report states that:

“The total number of medical and paramedical staff for psychiatric care is seriously inadequate and falls far short of meeting the universally established and recognised norms in this area”.

73. CNDH also identify that in theory there should be psychology, outpatient therapy, occupational therapy and social workers allocated to psychiatric units but that “Very few institutions have even one of these specialists, and even fewer have all of them.” The same report states that admission to hospital is not easy due to overcrowding and that “Care is generally basic” with the “latest generations of drugs are unavailable and drugs are often not stored in accordance with accepted standards”. CNDH also observed that “dysfunctionalities observed in relation to hygiene are numerous and seriously prejudice the right of patients to decent accommodation which protects their dignity”. Further, “pathways to reintegration are virtually non-existent, which frequently means that the therapeutic process comes to a complete halt.” Paragraph 15 sets out comments made by CNDH on the “acute lack of psychiatrists and psychiatric units in the private sector”.

74. In paragraph 17 Ms Elliot sets out the likely cost of some of the medications that have been prescribed for the appellant. The country evidence as a whole confirms that this medication would have to be paid for if not covered by the two health insurance schemes available in Morocco. Where Ms Elliott does not indicate her source for the costs provided, however, I was not able to accept the specific amounts set out. It would appear that some of the appellant’s heart medications are available in Morocco, specifically eplerenone, furosemide, ramipril and bisoprolol (the latter two being referred to by Ms Elliott as “Runipril” and “Biseprlol”).

75. I asked Mr Avery whether anything in the materials showed that the appellant's depot injection of zuclopenthixol decanoate was available in Morocco. He confirmed that he did not think that there was. There was also no reference to the availability of sodium valproate.

Discussion

76. There was agreement that the correct test to be applied to the appellant's Article 3 ECHR medical claim is that identified by the Supreme Court in AM (Zimbabwe) v SSHD [2020] UKSC 17. The Supreme Court accepted that the European Court of Human Rights (ECtHR) in Paposhvili v Belgium [2017] Imm AR 867 redefined what comes within the "other very exceptional cases" category beyond the D v UK 24 EHRR 423 and N v UK 47 EHRR 885 "deathbed" cases.
77. The Supreme Court confirmed that in paragraph 183 of the judgment in Paposhvili the ECtHR identified that a real risk in the receiving country of being exposed to either "a serious, rapid and irreversible decline in health resulting in intense suffering" or "a significant reduction in life expectancy" could meet the Article 3 threshold; see paragraph 22.
78. The Supreme Court also confirmed that an appellant's evidence had to be capable of demonstrating "substantial" grounds for believing that it was a "very exceptional case" because of a "real" risk of subjection to "inhuman" treatment. An appellant had to put forward a case which, if not challenged or countered, would establish a violation of Article 3. It was open to the returning state to seek to challenge or counter the evidence by dispelling any "serious" doubts raised by the appellant's evidence; see paragraph 33.
79. It is my conclusion that this appellant meets the high threshold for a finding of an Article 3 ECHR breach were he to be deported to Morocco.
80. The evidence on the seriousness of the appellant's chronic mental health problems and heart condition is very clear. There is no serious discrepancy in any of the documents provided from any of the medical professionals who have dealt with MAH. His profile is not merely of someone who suffers from a serious relapsing and remitting mental disorder that responds to medication. Even when treated with optimal medication, he presents consistently as unable to manage even basic daily living skills and requires a high level of assertive, specialist support to maintain any quality of life. The history shows that when this level of support is not in place, the appellant becomes unable to comply with his medication or engage with services and becomes seriously ill, homeless, destitute and vulnerable to exploitation by others. Without his daily heart medication and regular monitoring of his heart condition he is at risk of another potentially fatal heart attack.
81. The country materials on provision for mental health care in Morocco do not show that the appellant's needs will begin to be met. He will be entirely isolated on return to Morocco, not having lived there for 37 years. Mental health treatment is not available through the government AMO or RAMED schemes. Only emergency treatment is covered by the insurance schemes and other treatment has to be paid for.

Without a great deal of professional psychiatric support, the appellant is not capable of enrolling on either of the insurance schemes, negotiating any kind of bureaucracy or accessing any kind of medical treatment or support. He is not capable of obtaining an income so cannot pay for any treatment or medication. Nothing in the materials shows that the high level of assertive support he needs to prevent a deterioration to the level seen in 2019/2020 would be available even if the appellant could pay for it and manage to access it. The respondent's RIR from November 2018 states that sheltered housing for psychiatric patients is not available, for example.

82. In my judgment, the appellant's history shows that on return to Morocco he will become homeless and destitute immediately, be unable to access even the limited treatment that is available or engage with any kind of services that might be available to offer basic support. He will experience a serious relapse, become psychotic, extremely vulnerable and self-neglecting and be at risk of death from a heart attack as he will not be able to access medication or monitoring for his heart condition. The prospects for MAH on return would be so bleak that it is my view that he would face both "a serious, rapid and irreversible decline in health resulting in intense suffering" and "a significant reduction in life expectancy".
83. It is also my conclusion that where that is so he would also face a disproportionate breach of his rights under Article 8 ECHR. This has to be the case where, albeit he may not meet the statutory exemptions to deportation, the extremity of his position on return amounts to "very compelling circumstances" capable of outweighing the public interest.
84. For all of these reasons, I find that the appeal should be allowed under Article 3 and Article 8 ECHR.

Decision

The appeal is allowed under Article 3 and Article 8 ECHR.

Signed: *S Pitt*
Upper Tribunal Judge Pitt

Date: 15 August 2021