



Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: PA/05999/2018

THE IMMIGRATION ACTS

Heard at Field House
On 23 January 2020 & 2 September 2021

Decision & Reasons Promulgated
On 15 October 2021

Before

UPPER TRIBUNAL JUDGE O'CALLAGHAN

Between

AM
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr. S Clark, Counsel, (23 January 2021) and Mr. A Eaton,
Counsel (2 September 2021) instructed by Duncan Lewis
Solicitors

For the Respondent: Mr. T Melvin, Senior Presenting Officer

DECISION AND REASONS

Unless the Upper Tribunal or a Court directs otherwise, no report of these proceedings or any form of publication thereof shall directly or indirectly identify the appellant. This direction applies to, amongst others, the appellant and the respondent. Any failure to comply with this direction could give rise to contempt of court proceedings

Introduction

1. The appellant is a national of Somalia. He appeals against a decision of the respondent to refuse to grant him leave to remain on human rights grounds following representations made in relation to a decision to deport him. The respondent's decision is dated 11 April 2018.
2. In addition to the human rights appeal presently before this Tribunal the appellant initially appealed on protection grounds, but this element of his appeal was dismissed by the First-tier Tribunal. He did not secure permission to appeal from that aspect of the First-tier Tribunal's decision. A judicial review challenge concerned with the refusal to grant permission to appeal on protection grounds was dismissed by the High Court.
3. The parties agree that the issue before this Tribunal is the appellant's human rights (articles 3 and 8 ECHR) appeal.

Anonymity Order

4. I made an anonymity order on 16 August 2019. The parties have not requested that it be set aside.
5. I note the observation of Elisabeth Laing LJ in *Secretary of State for the Home Department v. Starkey* [2021] EWCA Civ 421, at [97]-[98], made in the context of deportation proceedings, that defendants in criminal proceedings are usually not anonymised. Both the First-tier Tribunal and this Tribunal are to be mindful of such fact. I am satisfied that the appellant in this matter has already been subject to the open justice principle in respect of his criminal convictions, which are a matter of public record and so considered to be known by both the local community and the wider public.
6. I observe that it will usually be in the public interest for deportation proceedings to be conducted by means of open justice. However, I am mindful that the appellant has significant mental health concerns and such concerns have to be addressed in this decision. I conclude on the particular facts arising in this matter that the common law right permitting the public to know about Tribunal proceedings, a right further protected by article 10 ECHR, is outweighed by the appellant's rights under article 8 ECHR: *Cokaj (anonymity orders, jurisdiction and ambit)* [2021] UKUT 202, at [17]-[28]. I therefore do not set aside the order, as I am satisfied that there is a likelihood of serious harm arising to the appellant from the contents of his claim being publicly known.
7. The order is detailed above.

Procedural History

8. The proceedings in this matter have an extensive history. The First-tier Tribunal (JFtT Housego) dismissed the appellant's protection and human rights appeal by a decision dated 5 December 2018. The appellant appealed, relying upon five identified grounds of challenge. The Upper Tribunal (UTJ Smith) granted permission to appeal on grounds one to three alone by a decision dated 20 February 2019.
9. The appellant challenged the failure of the Upper Tribunal to grant permission to appeal on all grounds by way of a 'Cart' challenge under CPR r.54.7A. Permission to apply for judicial review was refused by Lang J whose order is dated 18 April 2019.
10. Following an error of law hearing I set aside the decision of the First-tier Tribunal on 16 August 2019 with the caveat that the findings of fact made by JFtT Housego in relation to the certificate issued under section 72 of the Nationality, Immigration and Asylum Act 2002 ('the 2002 Act') and the application of section 8 of the Asylum and Immigration (Treatment of Claimants) Act 2004 stood. The lawfulness of the section 72 certificate was determinative of the appellant's refugee appeal. I directed that the decision on the outstanding human rights matter be remade by this Tribunal.
11. The resumed hearing came before me on 23 January 2020. Consequent to the oral evidence of Dr Reddy, consultant psychiatrist, the hearing was adjourned with the consent of the parties to permit the appellant to secure and file further evidence as to his present mental health diagnosis and treatment, issues upon which Dr Reddy appeared to lack relevant knowledge.
12. The Covid-19 pandemic resulted in the listed hearing on 17 April 2020 being vacated.
13. A case management review hearing was held on 9 October 2020. Observing the ongoing delay from the hearing of Dr. Reddy's evidence, the parties were asked whether they wanted the hearing to recommence on a *de novo* basis before a different Judge. There was agreement as to my continuing to hear the matter.
14. This matter was listed as a hybrid hearing at Field House on 18 January 2021 with the representatives attending remotely and the appellant attending in person. Unfortunately, it proved impossible on the day to make a screen available that permitted the appellant to view the representatives. It was decided that proceeding in such circumstances would not be fair and the hearing was adjourned.

15. The resumed hearing took place on 2 September 2021. The appellant was permitted to attend remotely as there were concerns as to the potentially adverse impact upon his mental health that may arise from his travelling unaccompanied to the hearing centre. Observing the delay in concluding this matter the representatives confirmed that the parties were content that it was not necessary in respect of fairness for the resumed hearing to be recommenced *de novo* before a different judge.

Background

16. The appellant is a Somali national who is aged 30. His father died when he was aged around 8 years old. His mother moved away, remarried and relocated with her second family to the United Kingdom. The appellant and his brother were left in Somalia with an unrelated family who were farmers.
17. In May 2005, along with his brother, the appellant applied for entry clearance to join his mother, who had settled in this country. The application was initially refused but in July 2008 the appellant was successful in his appeal on human rights grounds. In the meantime the appellant had left his abusive guardians and relocated to Ethiopia. He entered the United Kingdom in 2009, when aged 18, with indefinite leave to enter.

Criminal convictions

18. On 10 September 2016 at East London Magistrates' Court the appellant was convicted of being drunk and disorderly and fined £200.
19. On 12 October 2016 at Snaresbrook Crown Court the appellant pleaded guilty at the first opportunity in respect of one count of attempted robbery and one count of breach of bail. On 11 November 2016 he was sentenced to three years' imprisonment in respect of the attempted robbery, with no separate penalty imposed for the bail offence. HHJ Kennedy remarked in sentencing the appellant, *inter alia*:

'Earlier this year you robbed a woman late at night [who] was on her own. You knocked her to the ground twice. You used such force that the strap on her handbag broke. You were with somebody else. You were heavily under the influence of alcohol. You have been on a binge for some days. You have pleaded guilty. I am satisfied that this case falls within medium culpability and category 2 because you targeted a woman who was perceived to be vulnerable. Fortunately, she had the courage to scream.

As your learned counsel concedes, it must have been a terrifying and a very frightening experience for the unfortunate woman. You were with somebody else, it was at night, and you were heavily under the influence of alcohol. The factors in your favour are that you have no previous convictions and that you

do have a mental disorder unfortunately and I have read with sympathy the pre-sentence report and the faithful and helpful psychiatric report about you.'

20. The medical report referred to by the sentencing judge was authored by Dr. Church, consultant psychiatrist, and dated 11 October 2016. Dr Church recorded the appellant's history of alcohol abuse from the age of 18 years, resulting in his sleeping rough on occasion. At one point the appellant confirmed drinking three 700ml bottles of vodka per day. The appellant engaged in episodes of heavy alcohol consumption with a maximum twelve months of abstinence in the seven years preceding his conviction.
21. The appellant informed Dr Church that he had been admitted to a mental health hospital whilst in Ethiopia, prior to travelling to the United Kingdom. Following his arrival in this country, whilst residing in a hostel, he began to feel paranoid and held a belief that another person was performing black magic upon him. The appellant confirmed in interview with Dr Church that he experienced disturbance of auditory perception, for example hearing a baby shout his name, and that he heard unpleasant auditory hallucinations which prompted him to place blankets on his doors and windows.
22. Dr Church noted that the appellant had been admitted to a psychiatric hospital in this country and at the time of the report was under the care of an early intervention team in respect of his mental health.

Deportation proceedings

23. A deportation order was issued by the respondent on 11 April 2018, accompanied by a notice of decision of the same date.

Mental health

24. The appellant's primary psychiatric illness has been diagnosed as paranoid schizophrenia, coupled with his experiencing a major depressive disorder (recurrent moderate) and PTSD of varying severity. He has experienced psychotic episodes which have required hospitalisation and treatment with a depot injection.
25. The Tribunal has been provided with extensive medical evidence concerning the appellant, including expert reports, letters from treating consultant psychiatrists and relevant medical records.
26. Details as to paranoid delusion permeate the appellant's medical records filed with the Tribunal which run from 2011. The records confirm that for several years the appellant was prescribed olanzapine, an antipsychotic medication. By the summer of 2020 the appellant reported that his changed prescription of

quetiapine, an antipsychotic medicine, was helpful but his voices had escalated. They were calling his name or telling him to change his clothes. Medical evidence confirms that at the present time the appellant is receiving multi-modal and multidisciplinary care.

27. Dr Walker, consultant psychiatrist, who is presently treating the appellant, observed by his letter of 7 December 2020 that the appellant is no longer using alcohol or drugs. However, he spends all his time in his flat as the local library is not open and he feels desperately lonely. He admitted to some suicidal thoughts but identified no specific plans. The appellant reported to Dr Walker on several occasions that his auditory hallucinations are severe, distressing and derogatory. They were with him most of the time. Dr Walker observed that the appellant has insight into his condition as he accepts that he has an illness and acknowledges that he has to engage with treatment. However, the medical reports record frequent failure by the appellant to engage with healthcare professionals.

Physical health

28. The appellant suffers from hereditary angioedema caused by C1 esterase inhibitor deficiency, resulting in swelling of the lower layer of skin and tissue just under the skin or mucous membranes. He recently reports swollen and painful feet.
29. The appellant self-medicates firazyr, a peptidomimetic, on a fortnightly basis. In his report of January 2020 Dr Hoehne confirms that this medication is not available in Somalia. Dr. Hoehne further observed that treatment for angiodemia following an acute episode leading to hospitalisation can cost over US\$500 in Somalia.
30. By a letter dated 6 August 2019, Dr Yeatman, clinical immunologist, details that the condition requires skilled medical care regarding treatment and monitoring and it may require emergency safeguarding of the airway. Such treatment is not available in Somalia. Dr Yeatman observed that a relative of the appellant, who suffered from this condition, died of airway obstruction.

Section 32 of the UK Borders Act 2007

31. Having been sentenced to a custodial term of over twelve months, the appellant is a foreign national prisoner as defined by section 32 of the UK Borders Act 2007 ('the 2007 Act'). Section 32(4) of the 2007 Act conclusively treats his deportation as being conducive to the public good as does paragraph 396 of the Immigration Rules ('the Rules'), which states that it is in the public interest to deport where the respondent must make a deportation order in accordance with section 32. Nevertheless, paragraph 397 of the Rules provides that a deportation order will not be made if the person's removal pursuant to the order would be contrary to

this country's obligations under, *inter alia*, the ECHR. Where deportation would not be contrary to this country's obligations, it will only be in exceptional circumstances that the public interest in deportation will be outweighed.

Parties' submissions

32. Mr. Melvin did not object to the appellant relying upon evidence filed post- the First-tier Tribunal hearing. He also made no objection to the appellant relying upon evidence concerning 'chaining' in Somalia, which was not an issue raised before the First-tier Tribunal.
33. By means of his careful and focused submissions, which built upon his various written submissions, Mr. Melvin accepted that the medical evidence established that whilst the appellant has insight as to his condition, he has shown reluctance to engage with medical professionals. He accepted that the appellant's conditions were managed by various medication, but the respondent's position was that such medication was available at reasonable cost in Somalia. The appellant can secure employment in Somalia and consequently secure medication.
34. Mr. Melvin acknowledged the undisturbed finding of JFtT Housego that clan assistance was unlikely because of the appellant's mental health concerns.
35. Mr. Eaton's submissions were helpful and succinct. He relied upon *AM (Zimbabwe) v. Secretary of State for the Home Department* [2020] UKSC 17, [2021] A.C. 633 and observed that sufficient evidence had been presented by the appellant to transfer the burden onto the respondent. He noted that even whilst taking his prescribed medication, the appellant was suffering hallucinations. He also relied upon the recent decision in *Ainte (material deprivation - Art 3 - AM (Zimbabwe))* [2021] UKUT 203 (IAC).

Decision

36. The parties have filed several skeleton arguments and submissions. I confirm that they have been considered with care, as have the documents filed by the appellant in his consolidated appeal bundle that runs to 1073 pages and his consolidated supplementary bundle running to 135 pages.
37. I take this opportunity to thank Mr. Melvin, Mr. Clark and Mr. Eaton for their careful, and very helpful, written submissions which has greatly aided my consideration of this matter. I am also grateful to Mr. Cartwright of Duncan Lewis Solicitors for the care he has taken in collating and filing the considerable number of documents in this matter.

Vulnerability

38. The parties agreed at the hearing that the appellant is a vulnerable individual and that the Tribunal should abide by the Joint Presidential Guidance Note No. 2 of 2010: '*Child, vulnerable adult and sensitive appellant guidance*'. The Tribunal accepts that the appellant is a vulnerable person due to his mental health and observes the judgment of *AM (Afghanistan) v. Secretary of State for the Home Department* [2017] EWCA Civ 1123; [2018] 4 WLR 78 in which the Court of Appeal gave guidance on the general approach to be adopted in law and practice by the Immigration and Asylum Chamber where claims are made by incapacitated or vulnerable persons whose ability to participate effectively in proceedings might be limited. The guidance is designed to ensure that such persons enjoy an effective right of access to the Tribunal, a voice in the proceedings and that their claims are fairly determined.

Burden and standard of proof

39. The burden is upon the appellant to establish that there has been an interference with his protected human rights. The respondent must show that deporting the appellant to Somalia will not result in a breach of his protected rights.
40. The standard of proof to be applied is the civil standard, though it is a flexible one in its application. *In re: B (Children) (Sexual Abuse: Standard of Proof) (CAFCASS intervening)* [2008] UKHL 35; [2009] 1 AC 11, at [14] - [15]. In *R (on the application of N) v. Mental Health Review Tribunal (Northern Region)* [2005] EWCA Civ 1605; [2006] QB 468, at [60], [62-64] and [68], the Court of Appeal held that the flexibility of the standard lay not in any adjustment to the degree of probability required for an allegation to be proved but in the strength or quality of the evidence that would in practice be required for an allegation to be proved. No more is required than that the decision reached by a Tribunal is based on cogent evidence on the balance of probabilities. The House of Lords approved this approach in *Re: D* [2008] UKHL 33; [2008] 1 WLR 1499.

Findings of fact

41. Adopting the approach to be applied when considering the evidence of vulnerable persons as identified by the Court of Appeal in *AM (Afghanistan)* I find that the appellant spent his early life in Somalia. He is a member of the Habar Gidir clan, a major subclan of the Hawiye. After his father died, his mother left Somalia, leaving the appellant and his brother with a family for whom the appellant worked as a livestock herder. Whilst working as a minor he was physically abused, being regularly subject to physical violence.

42. I find that the appellant is truthful as to having been sexually abused as a child. His PTSD is linked to such abuse, and I accept that he continues to have flashbacks of varying degree about such abuse. His PTSD and recall of events continue to have a deleterious impact upon his mental health.
43. I am satisfied to the required standard that the appellant left Somalia as a child and travelled to Ethiopia where he resided until he travelled to this country. He has therefore not lived in Somalia for at least 13 years. I find that the appellant had considerable mental health concerns relating to PTSD upon his arrival in this country, resulting in his mother directing him to medical care at an early stage. He started to experience symptoms of schizophrenia from 2010, including perceptual problems including tactile and auditory hallucinations. He was subsequently diagnosed as paranoid schizophrenic. He continues to suffer from significant mental health concerns that are long-standing and of a remitting relapsing nature. I accept that the pain and discomfort resulting from his physical ill-health exacerbate his mental health concerns.
44. I accept the medical evidence placed before me confirming that the appellant has poor cognitive functioning, slow decision-making, poor concentration and anxiety, impaired memory and low self-esteem. As to his paranoid schizophrenia, I accept that it has previously manifested itself with paranoid and persecutory delusions and has escalated to first person auditory hallucinations with him holding a belief that his mind and body could be influenced or controlled.
45. I accept the medical opinion placed before me that if the appellant were to relapse his likely manifested symptoms would include his paranoid and derogatory first-person auditory hallucinations causing him to be overly suspicious and accusatory against those around him with a level of oddity and intermittent lack of functionality.
46. I find that present-day Mogadishu is not a familiar city to the appellant. He resided in a rural area within Somalia and has never resided in the capital city. He has been absent from Somalia for some 13 years. I find that he has particular mental health issues that mean Mogadishu would be a very difficult place for him to know, understand and survive.
47. I accept that the appellant is estranged from his family in this country. I accept that he has not spoken to his mother since his arrest and imprisonment. Nor does he have a relationship with his three half-siblings. I further accept that his brother has serious mental health concerns, as detailed within the reports placed before the Tribunal. I observe that the appellant lives over 100 miles away from his family in this country and has lived apart from them for some time. No family member has supported the appellant in respect of his appeal, either by witness statement or by attending a hearing.

48. I find that the appellant has no close family residing in Somalia, nor does he have any friends in that country. He has no close friends in this country. He presently lives a solitary, unhappy life primarily focused upon staying in his room or attending a library when it is open. I find that he is now abstinent in respect of alcohol and drugs and has been for approaching two years.
49. I accept that he has enjoyed very limited employment in this country, having worked for approximately two months as a baker. He lost this employment through the impact of his mental health difficulties.

Article 3

50. It is well-established that the responsibility of a state will be engaged under the ECHR where substantial grounds have been shown for believing, for example in a deportation case, that the person concerned, if deported, faces a real risk of being subjected to torture or to inhuman or degrading treatment or punishment in the country of return. In so far as any liability under the ECHR is or may be incurred, it is liability incurred by the contracting state that is seeking to deport by reason of its having taken action which as a direct consequence exposes an individual to proscribed ill-treatment: *Soering v. United Kingdom* (1989) 11 EHRR 439, at [96]. The Strasbourg Court specifically confirmed in *Pretty v. United Kingdom* (2002) EHRR 1, at [52], that an act of expulsion can constitute treatment covered by article 3. The Strasbourg court has confirmed that there is no exception to the real risk test, even on national security grounds: *Chahal v. United Kingdom* (1997) 23 EHRR 413, at [79-82]. The ECHR has been incorporated into domestic law by the Human Rights Act 1998.
51. Ill-treatment has to reach a minimum level of severity to fall within the scope of article 3 and the question as to whether the minimum level has been reached in any given case will depend upon the facts, calling for an intensely fact-sensitive inquiry.
52. I am therefore required when assessing whether the proposed deportation constitutes 'inhuman treatment' to consider both the treatment concerned and the particular characteristics of the appellant. The Strasbourg Court confirmed in *Soering*, at [100]:

'As is established in the Court's case law, ill-treatment, including punishment, must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the case, such as the nature and context of the treatment or punishment, the manner and method of its execution, its duration, its physical or mental effects and, in some instances, the sex, age and state of health of the victim.'

53. Suffering which occurs as a result of naturally occurring mental and physical illness can fall within article 3: *Pretty*, at [52]; *R (S) v. Secretary of State for the Home Department* [2011] EWHC 2120 (Admin).
54. The requisite standard of proof was established in *Soering* as being where substantial grounds are shown for believing that the person concerned, if deported, faces a real risk of being subjected to treatment contrary to article 3. The degree of probability required to give rise to a breach of Article 3 in expulsion cases is indicated by 'real risk' while 'substantial grounds' refers to the amount of evidence necessary to prove the existence of such a risk. The standard of proof has been set particularly high in cases where the risk stems from factors which cannot engage the responsibility of the receiving state's officials, directly or indirectly, such as health-care cases.
55. The case law relating to the reach of article 3 in preventing removal of foreign nationals from this country was reviewed by the Supreme Court in *AM (Zimbabwe)*. The Court noted that the Strasbourg Court in *Paposhvili v Belgium* (App. No. 41738/10) [2017] Imm. A.R. 867 had stated that cases raising an issue under article 3 included 'situations involving the removal of a seriously ill person in which substantial grounds have 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, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy'. That new criterion means that, in cases of resistance to return by reference to ill health, article 3 might extend to a situation other than those in which there was an imminent risk of death in the returning state.
56. Consequently, an appellant seeking to rely upon article 3 and medical treatment has to adduce evidence capable of demonstrating that there are substantial grounds for believing that they will be exposed to a real risk of being subjected to treatment contrary to article 3 if removed. It is then for the respondent to dispel any doubts raised by that evidence. In doing so, it has to closely scrutinise the asserted risk; consider the foreseeable consequences of removal in the light of the general situation in the receiving state; consider how the appellant's state of health might evolve after removal; verify on a case-by-case basis whether the care available in the receiving state would prevent the appellant from being exposed to treatment contrary to article 3; and consider the extent to which the appellant would have access to care in the receiving state.
57. The appellant's mental illness is not contested by the respondent and so I have accepted above the medical evidence relied upon by the appellant as establishing the nature and extent of his illness.

58. In *MOJ and Others (return to Mogadishu) Somalia CG* [2014] UKUT 00442 (IAC), at [422], the Upper Tribunal confirmed that the fact that it had rejected the view that there is a real risk of persecution or serious harm or ill-treatment to civilians or returnees in Mogadishu does not mean that no Somali national can succeed in an article 3 claim. Each case falls to be decided on its own facts and there will need to be a careful assessment of all the circumstances of a particular individual.

Decision

Availability of treatment

59. The appellant is mentally unwell and even when taking appropriate medication, the evidence placed before this Tribunal confirms that he can act in a manner that makes him clearly identifiable as having mental health issues. Such behaviour has been identified as a level of oddity and intermittent lack of functionality. Before this Tribunal his appearances were marked by a tendency to rub his head and be distracted when conversing. I accept that consequent to his mental health concerns and accompanying vulnerability, he cannot be considered to be ‘an ordinary civilian’ in the sense deployed in *MOJ*.
60. The civil war destroyed much of Somalia’s healthcare infrastructure, which, in addition to the migration or death of health personnel, means that access to healthcare is greatly compromised. There is a lack of legislation on mental health and the sector is underfunded, leading to an inadequate response to the challenges faced by people with mental health conditions. Traditional and religious healers, mostly herbalists and faith healers, are the mainstay of the general population’s access to mental healthcare. I note that the World Health Organisation records only three psychiatrists as presently working in Somalia, a country in which approximately one-third of the eight million population are affected by some kind of mental disorder.
61. By its 2016 report, ‘*Culture, Context and Mental Health of Somali refugees*’, the UNHCR notes that the level of mental distress among people in Somalia is thought to be high. As for treatment:
- ‘Seeking emotional support and prayer, or reading the Qur’an are often the first resources utilised to overcome distress. Alternatively, the Qur’an may be recited by relatives or friends, or by a spiritual healer ... In cases where witchcraft is suspected as the cause of the illness, traditional healers are primarily consulted. Western psychiatric treatment is considered often as a last resort, or when ‘natural’ causes (such as distress related to war, etc.) need to be treated.’
62. That many Somalis consider Western psychiatric treatment to be a last resort is rooted in its limited and inconsistent availability, namely the difficulty in

accessing appropriate psychiatric care and medications, rather than scepticism about its efficacy. However, it is underpinned by cultural and social views as to the treatment of mental illness and as to the reasons for mental illness: see 2016 UNHCR report. It is appropriate to note that the appellant does not hold an adverse view, having insight into the benefits received from his treatment. However, I accept to the requisite standard that such opinion is deeply entrenched within Somali society, and it is highly likely to be held by the appellant's future neighbours and those in his local community, whom he may have to very soon rely upon if deported to Mogadishu. It was not asserted by the respondent that the appellant could fall back upon the support of social services, there being none in Somalia, so I accept that the appellant will have to fall upon his own resources. I find that he will receive no support from his family, clan or neighbours.

63. I further find that the appellant is currently subject to an evolving diagnosis, with dosages being regularly changed over time following review. Further, he requires regular blood tests as part of his anti-psychotic medication monitoring. His care needs are therefore greater than simply being able to access pharmaceutical medication, as was the case in *Bensaid v. United Kingdom* (App. No. 44599/98) (2001) 33 E.H.R.R. 10.
64. The appellant's expert, Dr Hoehne, confirms by his report dated 15 January 2020 that olanzapine is widely available in Somalia. However, a medical decision has been made by those treating the appellant that this medication is no longer suitable. As for quetiapine Dr Hoehne confirmed in email correspondence with the appellant's legal representatives that this drug is available in Somalia with a monthly cost in the region of US\$30-40.
65. I therefore proceed to the question of whether the appellant can access his required treatment on his return to Somalia. Ultimately, this is the core of the respondent's position before this Tribunal, it being asserted that the appellant can secure and sustain employment on return to Somalia and earnings from such employment will enable him to secure accommodation and purchase required anti-psychotic medication.
66. The burden rests upon the appellant to demonstrate that it is reasonably likely that he will not be able to secure a livelihood for himself in Mogadishu. I am satisfied that this burden has been discharged. Having considered all of the evidence, I am satisfied that he is a man considerably affected by his mental condition, to the point that his life is presently centred upon the room in which he lives with limited public excursions. He is not a socially able and personable man. He is a victim of childhood sexual abuse and continues to have distressing flashbacks of his abuse. Whilst having an insight into his mental condition and understanding the benefits of healthcare, he has regularly disengaged from healthcare professionals which in turn has impacted upon his healthcare. He has no personal

contacts in Mogadishu to aid him secure housing and employment, nor any knowledge of recruitment practices in the city. He has very limited experience of employment over the last 13 years, amounting to two months working at a bakery. His mental health had significantly impacted upon his ability to secure employment and I am satisfied that the adverse view of mental health prevalent in Somali society will not ease his inability to find work. The likelihood of his finding work is extremely limited, and he has no established history of successfully keeping employment even when he has been engaged with accepting medical treatment for his paranoid schizophrenia. I find to the required standard that the appellant will not secure employment on return to Somalia.

67. If, as I have found, the appellant is unable to find and secure employment, and with no family or clan assistance to fall back upon, I am satisfied that his mental health will quickly deteriorate, and any increase in the level of oddity will be noted by the general public. Mr. Eaton drew my attention to the lack of adequate psychiatric treatment in Mogadishu and Somalia generally, and the use of chaining.
68. The respondent's '*Somalia: Country Background Note*' (version 1) (December 2020) addresses mental healthcare in Somalia at para. 9.5. It notes a media report detailing:

'Mental health in Somalia is incredibly stigmatized. Many patients suffer neglect and abuse from caretakers at home and in hospitals. The mentally ill are traditionally chained or imprisoned: a form of treatment the Somalis believe will fix an individual with mental health problems. This is due to the lack of awareness and lack of therapy/treatment. As a result, many who need help will feel less inclined to reach out for help fearing being chained and/or taken away from their families...

'Presently only five mental health centers situated in Berbera, Bossano, Garowe, Hargeisa, and Mogadishu are treating patients with basic care. Many who suffer from mental illnesses, such as post traumatic stress disorder (PTSD), depression, anxiety, and others as a result of ongoing conflict and instability in the country, do not receive necessary medical care that could improve their mental health or mentally ill people.

'The WHO estimates that at least 90 percent of those who eventually seek help may have been chained at least once in their lifetime. The current resources that are being allocated to larger hospitals are often out of reach to those in low-income families ...'

69. Reference is also made to a media article from 2019 detailing, *inter alia*, that despite high rates of mental illness in Somalia, the country is unable to provide the most basic of care to those in need, many of whom are isolated, chained to hospital beds, or even jailed.

70. As for the general use of chaining, there is a very poor and partial understanding of mental health by the general public in Somalia. The word *waalan* is widely used throughout Somalia to define a person affected by a severe mental illness and has strong negative social implications, leading to social exclusion, isolation and stigmatisation. It is very hard for someone labelled *waalan* whose symptoms are reduced or controlled to reintegrate back into their communities. Mental illness is through to come from a range of causes, including as a result of God's will, from evil spirits, *sar* (spirit) possession, evil eye, curses and witchcraft, natural causes, stress and emotions. Significant social stigma exists around mental health conditions. Often ill-informed relatives are left with no place to turn to for help on how to support their relative with psychosocial disabilities. Many mentally ill persons are chained to trees or restrained within their homes, often for months or years. Chaining is often used to try and prevent people with severe mental disorder from committing an assault for which the family would be forced to pay compensation.
71. The 2016 UNHCR report observes:

‘Containment of the mentally ill through the use of chains is a widespread practice throughout Somalia, in both urban and rural areas, and also in refugee camps outside Somalia. Chaining people with a mental disorder is a harmful practice that often amounts to the violations of the human rights of the person. Chaining is practiced for both men and women and is often an act of despair by family members who feel they have no other way to handle a problem.’
72. The ongoing permitted use of chaining throughout Somalia, in particular within hospitals, clinics and inside and next to private residences in Mogadishu establishes to the requisite standard that the Somali authorities are unwilling and unable to intervene so as to protect the personal rights of mentally ill persons who find themselves contained by chains.
73. No evidence was filed with the Tribunal identifying a decrease in the use of chaining in Somalia.
74. The Country Background Note refers to care services provided by ‘Dr Habeeb’ in Mogadishu. Abdirahman Ali Awale, known locally as ‘Dr. Habeeb’ opened the Habeeb Mental Health Centre in Mogadishu in 2005. Dr. Hoehne confirms in his January 2020 report that Dr. Habeeb is a qualified nurse, not a psychiatrist, and engages in chaining mentally ill patients who are (auto)aggressive.
75. I therefore find that the appellant will be denied access to anti-psychotic medication through lack of resources. Further, there is a real likelihood, indeed a significant likelihood, that he will be subject to chaining in the community or in a hospital, either because he will act oddly or will aggressively engage with others.

In respect of the latter, I note entries in his medical records as to the appellant engaging in verbal aggressiveness with healthcare professionals. Whilst such events occur occasionally, they occur whilst the appellant is engaging with healthcare professional and taking his medication. I am satisfied that there is a real likelihood of verbal aggressiveness increasing in the absence of the appellant securing anti-psychotic medication. I further observe regular entries in the appellant's medical records as to neighbours complaining of anti-social behaviour. I am satisfied that the appellant's behaviour will quickly deteriorate in the absence of anti-psychotic medication and such behaviour will be noted by neighbours and the wider community in Mogadishu.

76. I find that there are substantial grounds for believing that the appellant will be exposed to a real risk of being subjected to treatment contrary to article 3 if removed to Somalia. The burden therefore falls upon the respondent to dispel any doubts raised by that evidence. The real risks of the appellant being left without financial resources and support upon return to Somalia, unable to access the anti-psychotic medication he requires, leading to his being chained as a containment measure foreseeably leads to irreversible decline in state of health resulting in intense suffering consequent to the lack of relevant healthcare provision in Somalia. The inability to pay for medication removes the appellant from any healthcare provision that does not run the real risk of using chaining. The respondent was unable to identify evidence dispelling the doubts raised by the appellant in light of both expert and documentary evidence. Indeed, the respondent placed her entire case upon the appellant being capable of securing and sustaining employment on return to Somalia, which ultimately proved to be unsustainable. I am satisfied that the respondent is unable to discharge the burden placed upon her.
77. I conclude that there is a real or significant risk of the appellant being unable to access required anti-psychotic medication upon return to Somalia, leading to his being chained as a containment measure, constituting ill-treatment reaching a minimum level of severity to fall within the scope of article 3.
78. Having reached such conclusion, I am not required to consider the impact of the appellant being unable to secure firazyr or suitable alternative medication upon return to Somalia, save to observe that the respondent provided no evidence to counter Dr Hoehne's confirmation that such medication is not available in Somalia. The absence of such required medication, and the risk of hospitalisation and death following a severe angiodemia episode, reinforces the conclusion reached above as to there being a real or significant risk of the appellant being subjected to ill-treatment reaching a minimum level of severity upon return to Somalia as to fall within the scope of article 3.

Prevailing country conditions

79. In the alternative, I observe the decision in *Ainte* where it was confirmed that the judgment in *Secretary of State for the Home Department v. Said* [2016] EWCA Civ 442, [2016] Imm. A.R. 1084 is not to be read to exclude the possibility that article 3 could be engaged by conditions of extreme material deprivation. Factors to be considered include the location where the harm arises, and whether it results from deliberate action or omission. In cases where the material deprivation is not intentionally caused the threshold is the modified test to that established by the House of Lords in *N v. Secretary of State for the Home Department* [2005] [2005] UKHL 31, [2005] 2 AC 296, as set out in *AM (Zimbabwe)*. The question is whether conditions are such that there is a real risk that the individual concerned will be exposed to intense suffering or a significant reduction in life expectancy.
80. I note that in *MOJ* the Tribunal heard evidence that there is a broad spectrum of circumstances in which people live in Mogadishu. At one extreme the wealthy live in gated compounds guarded by armed security personnel. At the other are the dispossessed who live in makeshift dwellings described by Mary Harper as ‘igloos’, “made of sticks, cloth, plastic, metal. Not tents. Dwellings. Crammed into patches of spare ground, closely together. Inside there is just sand or cardboard or plastic on the ground”. The Tribunal accepted that life in such a structure amounted to destitution, at [182], and could properly be described as ‘appalling’, at [411]. Where an individual returnee was likely to end up depended on a number of factors, including whether he had family connections, was in receipt of remittances or another source of income, and whether he was able to work to support himself. The Tribunal concluded, although it was not given evidence on the point, that logically there must also be types of dwellings falling somewhere in the middle of this spectrum.
81. Nothing in the evidence filed in this matter establishes that this spectrum, or the circumstances at its polar extremes, has materially changed.
82. I observe the respondent’s acceptance that the appellant has never lived in Mogadishu and cannot expect support from his clan upon return consequent to his mental health. For the reasons detailed above, I am satisfied that the appellant’s mental health concerns, even when treated by anti-psychotic medication, will prevent him from obtaining the work that he needs to rebuild his life. I further observe my findings above that the appellant is estranged from his family, and so cannot expect remittances from them, and has no family living in Somalia. He therefore has no other source of income. The appellant is excluded from securing funds under the facilitated return scheme. The respondent’s guidance, ‘*Facilitated Return Scheme (FRS)*’ (Version 8.0) (3 October 2016) confirms that if he were to make an application it would be refused because he has been sentenced to less than four years imprisonment in relation to a serious offence and

has pursued an immigration appeal beyond the First-tier Tribunal. I therefore proceed on the basis that the appellant will be returned to Somalia without the benefit of any grant under the scheme. Accordingly, I am satisfied that it is reasonably likely that he will enjoy no access to funds upon arrival in Somalia and thereafter.

83. In such circumstances, I am satisfied that the appellant will have considerable difficulty in readjusting to life upon return to Somalia. Further, through his inability to find and secure employment, coupled with the likely expeditious deterioration in his mental health, I find that he will be reduced to living in makeshift accommodation, or sleeping rough as he has previously in this country, and so consequent to his particular personal circumstances will find himself experiencing intense suffering of the kind envisaged by the Strasbourg Court in *Paposhvili* and the Supreme Court in *AM (Zimbabwe)*.
84. I therefore conclude that the appellant succeeds on article 3/ article 15(b) of the Qualification Directive grounds.

Article 8

85. At the hearing I allowed the appeal at the hearing on article 3/ article 15(b) of the Qualification Directive grounds.
86. Article 8 can therefore be addressed briefly. I observe section 117B and C of the 2002 Act and am mindful that the appellant is a foreign criminal. I note the guidance provided by the Supreme Court in *Hesham Ali v. Secretary of State for the Home Department* [2016] UKSC 60; [2016] 1 W.L.R. 4799. For the reasons detailed above, the only proper conclusion that can be reached in this matter is that very compelling circumstances exist so as to result in the appellant's article 8 private life rights outweighing the public interest in his deportation to Somalia.
87. I therefore allow his appeal on article 8 grounds.

Notice of decision

88. By means of a decision dated 18 August 2019 this Tribunal set aside the decision of the First-tier Tribunal promulgated on 5 December 2018 pursuant to section 12(2)(a) of the Tribunal, Courts and Enforcement Act 2007.
89. The decision is re-made, and the appellant's appeal is:

- i) Allowed on humanitarian protection grounds (article 15(b) of the Qualification Directive as incorporated domestically by paragraphs 339C and 339CA(iii) of the Immigration Rules).
- ii) Allowed on human rights (article 8) grounds.

Signed: *D O'Callaghan*
Upper Tribunal Judge O'Callaghan

Date: 4 October 2021