



Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: IA/04592/2012

THE IMMIGRATION ACTS

Heard at Field House
On 9 May 2014

Determination Promulgated
On 2 October 2014

Before

UPPER TRIBUNAL JUDGE MOULDEN
UPPER TRIBUNAL JUDGE ESHUN

Between

MR O D
(Anonymity Direction Made)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr A Mackenzie of counsel instructed by Sutovic and Hartigan

For the Respondent: Miss Busch of counsel instructed by Treasury Solicitors

DETERMINATION AND REASONS

1. The appellant is a citizen of Liberia who was born on 10 June 1985. He appealed against the respondent's decision of 17 February 2012 to refuse to revoke a deportation order made against him.

Immigration and appeal history

2. The appellant arrived in the UK on 26 August 2003 and claimed asylum. The claim was refused on 10 October 2003 and his appeal against that decision was

dismissed on 8 January 2004. Permission to appeal was refused on 26 February 2004 and on 13 October 2004 he was recorded as an absconder.

3. The appellant next came to the attention of the respondent on 7 October 2008 when he was convicted of possession of a false identity document and making false representations. On 5 December 2008 he was sentenced to 8 months imprisonment and the judge made a recommendation that he be deported.
4. On 30 January 2009 the appellant was served with a notice of decision to make a deportation order. He appealed, claiming that he had been a boy soldier and was tortured in Liberia. He was interviewed, after which the respondent made a fresh deportation order under s 5(1) of the Immigration Act 1971. The appellant appealed and his appeal was dismissed on 22 April 2009.
5. On 22 July 2009 the appellant made a fresh application for asylum which was refused on 30 October 2009. A deportation order was signed on 1 July 2010 and he submitted further representations on 7 December 2010 and 19 October 2011. The refusal letter states that he made an asylum claim on 14 April 2011 which was treated as an application to revoke the deportation order made in 2010.

The appeal hearing before the First-Tier Tribunal

6. It is the respondent's decision of 17 February 2012 to refuse to revoke this deportation order which has led to the present appeal proceedings.
7. The appellant appealed against this decision and his appeal was heard on 24 May 2012 by a panel consisting of First-Tier Tribunal Judge DJ Baker and non-legal member Mr AF Sheward ("the panel"). Then and since the appellant has been represented by Mr Mackenzie. The appellant did not give evidence. The panel heard evidence from two friends of the appellant and a consultant psychiatrist, Professor Katona. At an earlier hearing it was not accepted that the appellant was from Liberia. However, by the time of the hearing before the panel the respondent accepted that he was a Liberian from Liberia. In previous appeals the appellant's evidence as to what had happened to him in Liberia had, on the whole, not been believed. The panel observed that they had much more evidence including psychiatric evidence. The panel accepted that the appellant suffered from complex PTSD, had been a child soldier in Liberia and had witnessed and taken part in atrocities. Members of his family had been killed and his house burned down before he was taken by the rebels. The scars he bore were consistent with his claims to have been tortured. He had suffered ill-treatment at the hands of the rebels. We will need to return to the panel's findings in more detail.
8. Mr Mackenzie has not sought to argue that the appellant would still be at risk at the hands of the rebels or the authorities or that he would not be able to rely on a sufficiency of protection. It was accepted that he might face discrimination as a result of his mental health but he would not face a real risk

of persecution for that reason. In relation to the Article 3 grounds the panel concluded that whilst there was a risk that an adverse decision would lead to a suicide attempt neither this nor the situation he would face on return in relation to his mental ill-health would reach the high threshold required by Article 3.

9. The panel went on to consider the Article 8 private and family life grounds. The appellant did not have a history of offending and was at low risk of reoffending. He was suffering from a serious mental illness and would not have the support of either family or friends in Liberia. The disruption of his treatment and relationships caused by removal would increase the risk of suicide. Balancing these factors against the public interest, the panel concluded that it would be a disproportionate interference with the appellant's right to respect for his private and family life to remove him. The appeal was allowed on Article 8 human rights grounds only and by implication dismissed on asylum and Article 3 grounds.

The appeal to the Upper Tribunal

10. The appellant applied for permission to appeal to the Upper Tribunal arguing that the panel erred in law by failing to allow the appeal on asylum and/or Article 3 human rights grounds. Permission was granted by a judge in the First-Tier Tribunal. The appeal came before Deputy Upper Tribunal Judge Rimington ("the DUTJ") on 4 January 2013. She found that the panel had erred in law. There was a lack of reasoning and no specific finding as to whether the appellant was a member of a particular social group. The assessment of persecution had not fully taken into account all the evidence including the evidence of Dr Harris, a psychiatrist practising in Liberia, relating to social ostracism, destitution and harmful treatment. There had not been sufficient consideration of whether the particular circumstances of this appeal made it either an exceptionally compelling case contemplated in N v UK (2008) 47 EHRR 39 or whether the circumstances were such that a different test might need to be applied. Having concluded that the panel had erred in law the DUTJ set aside the decision.
11. Since then there have been a number of hearings. Following a case management hearing on 23 October 2013 directions were given that the scope of the appeal should be that set out in paragraph 4 of the appellant's Statement of Case dated 13 October 2013 and paragraph 2 of the respondent's Statement of Case dated 22 August 2013. The panel's findings of facts set out in the following paragraphs were preserved; 97 to 106; 114 (first four sentences; NB the FTT's findings as to risk are findings regarding the position as at the date of the FTT hearing); 115 to 120. There were also directions as to expert reports, further documentary evidence, skeleton arguments and authorities. Some of these have been modified at subsequent directions hearings, largely as to timing.

12. It is important to note that the directions given on 23 October 2013 included the following; “The decision of the FTT to allow the appellant’s appeal by reference to Article 8 of the ECHR has not been challenged by the respondent and cannot be challenged by her in the forthcoming appeal hearing.” The respondent has not sought to challenge this. We have been told and both representatives accept that the respondent has granted the appellant leave to remain in the UK for a period expiring in March 2015. We have not been shown the document granting this leave or told why it was granted although it is likely to have been as a result of the success of his appeal before the panel on Article 8 human rights grounds.

The hearing before us

13. The appellant did not attend the hearing before us. His representatives had indicated that two witnesses would be called, Professor Katona, who was present, and Dr Harris who would be giving evidence by video link from Monrovia in Liberia. The video link arrangements had been set up but did not work well enough for his evidence to be taken in this way. In the circumstances both counsel agreed that his reports should stand as evidence in chief, written questions would be submitted to him by way of cross examination followed by further written questions by way of re-examination. Thereafter each side would make further written submissions. We gave detailed directions as to how these steps should be taken.

14. We heard oral evidence from Professor Katona who gave evidence in chief, was cross examined and re-examined. His evidence is set out in our record of proceedings.

15. Since the hearing and with some extensions of time we have received the written questions submitted by the respondent to Dr Harris and his replies, in effect cross examination and then the written questions submitted by the appellant to Dr Harris and his replies, in effect re-examination. These were followed by the respondent’s supplementary closing submissions and then the appellant’s supplementary closing submissions.

Respondent’s Submissions

16. Miss Busch relied on her skeleton argument. In relation to the Article 3 grounds she relied on N v UK (2008) 47 EHRR 39 and submitted that the appellant’s circumstances came nowhere near this threshold. Whilst the case law recognised that there might be other very exceptional categories there was no authority for any suggestion that the threshold had been lowered. We were bound by the authorities and it was not open to us to lower this.

17. It was argued that the closest the jurisprudence had come to recognising the possible existence of another category or other circumstances was in GS and EO (Article 3 – health cases) India [2012] UKUT 00397 (IAC). The appellant

was not entitled to any particular level of treatment in the receiving State and he would not approach the level of deathbed destitution.

18. Miss Busch placed considerable reliance on AJ Liberia v Secretary of State for the Home Department [2006] EWCA Civ 1736. Whilst this appeal had been allowed it was only to the extent of being remitted to the Tribunal for further consideration. The law was set out between paragraphs 11 and 19. No suicide risk case had succeeded. Suicide cases should be approached in the same way as ill health cases (MSS v Belgium and Greece (2011) 53 EHRR 2, Sufi and Elmi v UK (2012) 54 EHRR 9 and SHH v UK (App No 60367/10)). The reasoning in paragraphs 88 to 95 of SHH was pivotal. In the appeal before us the appellant was not dying or at risk of dying either as a result of his mental ill-health or by suicide. Professor Katona had accepted that his conclusion that the appellant was at risk of suicide was, in his own words, based on no more than “informed speculation”. There had been no previous attempts to commit suicide. There was no evidence that the appellant’s condition had deteriorated as a result of any previous decisions by the respondent. He had never been hospitalised and he was able to work. He was able to function in a normal environment. Over time his depression had improved significantly. He was better now than he was before treatment.
19. Miss Busch pointed out that the country report suggested that 44% of the population of Liberia suffered from PTSD. The information submitted by the appellant at pages 1 to 14 of his supplementary bundle related to other individuals showed an improving situation for the treatment of mental ill-health in Liberia and that the antidepressant drug the appellant was taking (Mirtazapine) was likely to be available. She accepted that the position had to be considered on the basis of a hypothetical return to Liberia at the date of the hearing.
20. In relation to the Refugee Convention and Qualification Directive Miss Busch also relied on her skeleton. The appellant’s mental ill-health was not an immutable characteristic; it was changing with treatment. It was not possible to identify people who were mentally ill as a particular social group because of the wide range of possible conditions. She submitted that the evidence did not show that he would be persecuted because of his mental ill-health. Such evidence as there was related to stigmatisation and indicated that the authorities were taking steps to address this. There was no evidence that the appellant would be persecuted.
21. In her reply to Mr Mackenzie’s submissions Miss Busch submitted that Y was fact sensitive and an extreme case. We were asked to look at the appellant’s statements as well as Professor Katona’s reports. In his statements the appellant said nothing about suicide or suicidal ideation. In all the cases to which we had been referred the claimants were either dying or would inevitably die if returned. There was no clear evidence of the risk of suicide if the appellant was returned. If 44% of the population of Liberia was suffering from PTSD then a decision in the appellant’s favour would risk drawing to

this country large numbers of people wishing to obtain the benefit of psychiatric treatment which would result in an enormous commitment of resources. There was nothing exceptional about the appellant's circumstances and "mentally ill people" was too wide a category for the particular social group to be defined with any accuracy. There was no clear evidence that mentally ill people in Liberia were persecuted or that the appellant would stand out as a mentally ill person.

22. The respondent's supplementary closing submissions emphasise aspects of Dr Harris' replies to written questions, in particular that the appellant would not come within the category of persons liable to roam the streets in deplorable conditions who would be subjected to ridicule and/or ostracism. It is emphasised that the evidence did not support the conclusion that the appellant's circumstances reached the high threshold set out in *N v SSHD* or any other threshold which would satisfy Article 3. It would not be appropriate to make a comparative assessment of medical facilities in Liberia with those available in the UK. In the alternative, even if the appellant's claim were to succeed on Article 3 grounds by reason of his mental health and/or risk of suicide then he would not be entitled to a grant of humanitarian protection in the light of *MP (Sri Lanka) and NT (Sri Lanka) v SSHD [2014] EWCA Civ 829*.

Appellant's submissions

23. Mr Mackenzie relied on his skeleton argument and said that the appellant was not claiming Article 3 human rights protection independently of his claim for humanitarian protection; they were conjoined. It was not his primary argument that this appeal disclosed a new risk category falling within *N v SSHD* but that it fell within existing principles. We were not being asked to identify a new exceptional category. The appellant's submission was that cases based on mental ill-health had succeeded in the UK; he relied on *Y & Anor (Sri Lanka) v Secretary of State for the Home Department [2009] EWCA Civ 362*.
24. There was no reason why we should come to any different conclusion as to the appellant's state of health from that reached by the panel. We needed to determine his state of health now and how it would be if he was returned. Professor Katona's evidence was clear that there would be a significant increase in risk if he was returned. That risk would be of inhuman and degrading treatment. *J v SSHD [2005] EWCA Civ 629* established that the test required a high threshold of harm but not of risk. This appellant's situation was akin to that of the appellants in *Y*. We were asked to follow what he argued was the clear and authoritative test in *GS* and *EO* in paragraph 85 and, in particular, 85(5)(a). This appellant's case did show that he would be in "exceptional circumstances". The key elements were the absence of medical/psychiatric treatment, family or anyone else to care for him, homelessness and destitution. *AJ Liberia* assisted him because it showed that an individual going back to Liberia could succeed.

25. Mr Mackenzie submitted that Y showed that the question of the availability of appropriate treatment was a practical not a theoretical test. The cases before us showed that those claimants who failed did have access to medical treatment and/or family support. It was accepted that the appropriate threshold was the high one applicable to “foreign” cases. The evidence was that drugs on their own would not help him. 44% of the population of Liberia was thought to be suffering from PTSD and 40% of those had major depressive illnesses. The almost total lack of facilities needed to be looked at in this context. The evidence of Dr Harris was that he was the only qualified psychiatrist in Liberia.
26. In relation to persecution and particular social group, Mr Mackenzie submitted that the appellant would be at risk from the population at large because of his mental health difficulties. It was not argued that he would be at risk from the government or the authorities. The Convention reason was his membership of a particular social group namely “mentally ill people”. This group had immutable characteristics and a distinct identity within society. Only one of these was needed but he had both. In response to our question, Mr Mackenzie accepted that he was not aware of any authority for the proposition that “mentally ill people” belonged to a particular social group. He relied on LQ (Age: immutable characteristic) Afghanistan [2008] UKAIT 00005 for the proposition that “immutable” and “immutable characteristic” meant unchangeable not for all time but at any given moment.
27. We were asked to concentrate on what would happen to the appellant and the state of his health if he was returned to Liberia. In assessing the risk of suicide Professor Katona was not making wild or impermissible speculation but, as he described, “Informed speculation”.
28. The appellant’s supplementary closing submissions emphasise that the correct test in relation to the availability of treatment in Liberia was whether such treatment was now adequate and effective not whether it had improved and was less inadequate or less ineffective than it was at some earlier date. It is argued that the appellant remains entitled to humanitarian protection notwithstanding the decision in MP and NT because the risk of inhuman and degrading treatment does not arise solely from his medical condition but also from the risk of destitution arising from the dire humanitarian conditions in Liberia. Furthermore, the respondent’s own policy on humanitarian protection indicates that those at risk of ill treatment contrary to Article 3 on grounds of destitution or “dire humanitarian conditions” are entitled to humanitarian protection
29. Following oral submissions we reserved our determination which would be promulgated after the conclusion of Dr Harris’ written evidence and the receipt of further submissions from both counsel.

Findings of fact preserved

30. The panel's findings of facts contained in the following paragraphs were preserved; 97 to 106; 114 (first four sentences; NB the FTT's findings as to risk are findings regarding the position as at the date of the FTT hearing); 115 to 120. These were;

97. We have taken account of the determinations referred to above. We have also taken account of the guidance in **Devaseelan** and other cases referred to by Mr. Mackenzie. A finding of fact was made in April 2009 that the Appellant had not been tortured in Liberia. This was mainly because he had not referred to torture in his earlier appeal and we can understand why the finding was made and why the Respondent continues to doubt credibility. That is our starting point with regard to his account of events in Liberia.

98. It is clear that there was very little evidence before the Adjudicator in 2003 and neither party was represented and once again, it is not surprising that a different view of credibility was taken by the Panel in 2009. The only medical evidence of PTSD was from a GP and for reasons referred to above, that was rejected and the Panel were found not to have made an error of law in rejecting that evidence with regard to scarring. We note that there was limited evidence available at the 2009 hearing despite the fact that the Appellant was then represented.

99. We had the benefit of having a lot more evidence before us and in particular the detailed written and oral evidence of Professor Katona. He gave detailed oral evidence and was cross-examined at length. The Respondent did not produce an expert witness. Ms Pos cross-examined Professor Katona on his methods and possible alternative causes of his symptoms and we did not find that his evidence was undermined. Profesor [sic] Katona is clearly an expert in the field of psychology and competent to make a diagnosis of PTSD. We note that his evidence has been accepted in other Tribunal hearings as expert evidence. We find as a fact that the Appellant was suffering from a complex form of PTSD which in the opinion of Professor Katona would only be caused by some kind of repetitive interpersonal cruelty of the kind related to him by the Appellant who now claimed he had been a child soldier. Whilst it is not his role to decide on credibility, we do attach considerable weight to his assessment of clinical plausibility.

100. We take the view that it is highly unlikely that it would be possible for the Appellant to feign mental illness of the severity diagnosed over the period since 2009 and to fool both Professor Katona and Sally Solfe as well as the GP who initially diagnosed his problem. We find as a fact that he suffers from complex PTSD.

101. The cause of his illness is less straightforward. We have considered the possibility that it was the general experience of living in war-torn Liberia, being separated from his family or the death of his family, his experience of being convicted and sentenced for a criminal offence and his period of detention which caused the PTSD. However, we have no reason to doubt the

expert opinion of Professor Katona that even the cumulative effect of these events would not cause the kind of PTSD suffered by the Appellant.

102. We have been given an explanation for the delay in his disclosure of experiences as a child soldier. We have considered the submissions made by Ms Pos. It is the opinion of both Professor Katona and Sally Wolfe that it is unsurprising that someone would fail to disclose for some time and that they could function at a superficial level by not disclosing and reliving events. This would have been a defence mechanism. We reminded ourselves that at the initial appeal the Appellant was not represented. We accept that on the face of it he has been inconsistent in his accounts but taking the evidence in the round including the expert medical evidence of his mental state we find as a fact that he was a child soldier in Liberia. As a child soldier he witnessed many atrocities and was forced to take part in atrocities against others. We rely on the accounts given to Professor Katona and Sally Wolfe. We have also taken into account the statement he made in March 2009 although we accept that his account was not believed by the Tribunal. We have taken into account the report of Dr Arnold on the question of scarring and note that there was a level of consistency between his conclusions and the conclusions of the report of Dr Cooper, referred to above.

103. We believe the considerable amount of fresh evidence before us justifies departure from their findings on credibility. We also had a second report on scarring from Dr Arnold which post-dated the previous decision. At the very least, the scars were found to be consistent with the ill-treatment alleged by the Appellant. In his overall evaluation of the clinical evidence he felt it would be most unusual for a single individual to display the number, type and extent of scarring for reasons other than torture or organised violence.

104. We find as a fact that the Appellant's family members were killed and his house burnt down before he was taken by the rebels. He described in his statement that he was arrested by the peacekeeping force who saw his injuries and the state he was in and after a week he was put on a military truck and taken to Sierra Leone. He hid in a truck with peacekeeping soldiers and got on a flight to the UK.

105. We find that he suffered ill-treatment at the hands of the rebels in Liberia before he came to the UK in August 2003. By the time of arrival here he would have been 18 years old but we accept that he would have been a minor when he was forced to become a soldier.

106. The country situation in Liberia has changed significantly since that time. Mr. Mackenzie did not seek to argue that he would still be at risk from the rebels or the government or that he would not be able to rely on sufficient protection. We accept that he may have a subjective fear but find it is not well-founded.

114. We find as a fact that there is at least a risk that an adverse decision would lead to a suicide attempt although there has been no history of self-harm. Whilst in the UK the Appellant has access to professional mental health support and we have no reason to doubt that the Respondent would make suitable arrangements for his protection on the return journey in

accordance with her policy. We accept Ms Wolfe's opinion that returning him to the place where he suffered the trauma would be likely to place him at even higher risk. We find that he has no family there to support him.

115. Turning to Article 8, we note the findings of the previous Panel with regard to family life. We found the oral evidence of Mr. H insufficient to show that he had established a family life with his family. He was not living with them and whilst we had no doubt of the genuine good intentions of Mr. H, he was not even aware that the Appellant had worked, obtained false ID and been convicted and sentenced for that offence. Clearly the Appellant has established a private life over the years and we find as a fact that the H family have been friends since 2004. We also take into account the evidence of Mr. Hughes. He is an experienced retired Probation Officer and has formed a supportive and trusting relationship with the Appellant. We find as a fact that the Appellant has met his family and that these relationships are important to the Appellant's mental well-being.

116. We also find as a fact that the Appellant has only recently started individually focussed therapy with Ms Wolfe and that he is beginning to make some improvement. We accept the expert evidence as to the likely effect upon his progress of disruption to this treatment and removal from the supportive and trusting relationships he has established in the UK.

117. The circumstances have changed since the previous Panel decision in 2009.

118. We note that the Appellant did not have a history of offending and was regarded as of low risk of further offending at the time of sentence. He had committed one offence of using a false document to obtain work. We regard as particularly relevant the opinion of Mr. Hughes with regard to the Appellant's future if allowed to remain in the UK. He was an experienced former Chief Probation Officer who had worked for 36 years for the Probation Service. He did not consider that the Appellant was at risk of reoffending. He thought he would make a positive contribution if allowed to remain in the UK. We give weight to his views on this issue.

119. We note the decision in **MM** in which it was indicated that the UTJ had focussed on the issue of comparative availability of treatment and not on the question of proportionality and the importance of addressing the specific aspect of public interest relied on by the Respondent when considering Article 8. We are satisfied in this case that it would not be proportionate to deport the Appellant. We find that he would be of minimal risk of reoffending given the medical and social support he is receiving in the UK and lack of a history of offending. He is suffering from a serious mental illness and would not have support from family or friends in Liberia and would have to try and build new relationships in the country where he experienced the causes of his PTSD. The disruption to his current treatment and relationships caused by removal would increase the risk of suicide. This is a factor we have taken into the balance. We were not addressed by Ms Pos on the reception arrangements for him in Liberia to deal with the risk of suicide.

120. The legitimate public interest aim pursued by the Respondent is protection of the public from crime and disorder and we accept that includes an element of deterrence. However, we do not believe the Appellant poses a significant risk to the public in future and we do not believe that the need for deterrence alone can outweigh the adverse effect upon his mental health of removal. We find in the circumstances of this case there were grounds to revoke the deportation order.”

Scope of this appeal

31. The earlier directions in this case ordered that the scope of the appeal should be that set out in paragraph 4 of the appellant’s statement of case dated 13 October 2013 and paragraph 2 of the respondent’s statement of case dated 22 August 2013 these are, respectively;

“.....The issues to be determined in his appeal are:

- i. In light of his mental illness, would he be at real risk of inhuman and degrading treatment if he were returned to Liberia?
- ii. If so, does it follow that he is entitled to humanitarian protection?
- iii. Would he be at real risk of persecution if he were returned to Liberia?
- iv. If so, would such persecution be for a Convention reason, namely for reasons of membership of a particular social group, specifically mentally ill people.”
and

“On 26th of June 2013 the UT linked this appeal to that in Kalafallah v Secretary of State for the Home Department and listed both appeals to be heard after the decision of the Court of Appeal in AE (Algeria) v Secretary Of State for the Home Department. Specifically, the present appeal and that in Kalafallah were listed to be heard together (following the appeal in AE (Algeria)) in order to enable the UT to consider whether they disclosed enhanced circumstances, when considering whether the test of exceptional circumstances as set out in N (FC) v Secretary Of State for the Home Department [2005] UKHL is met, as envisaged by the Presidential Panel in the case of GS and EO (Article 3 – health cases) (India) [2012] UKUT 00397 (IAC).”

32. Whilst this appeal is no longer linked to Kalafallah we must still consider the full scope of this appeal, as defined.

Assessment of the medical/psychiatric evidence

33. The medical and psychiatric evidence is contained in the scarring report from Dr Cooper dated 12 March 2009, the Detainee Medical Records from 2009, the scarring report from Dr Arnold dated 4 September 2010, four psychiatric reports from Professor Katona dated 30 November 2010, 24 April 2012, 13 December 2013 and 1 February 2014 together with his oral evidence at the hearing and three reports from Sally Wolfe of “Freedom from Torture” (Formerly the Medical Foundation for the Care of Victims of Torture”) dated 5 April 2012, 3 May 2012 and 20 December 2013.

34. The findings of the panel which have been preserved remain valid at the date of that hearing in May 2012. However, they need to be reviewed in the light of any change in circumstances or opinions since then. We can see no reason to depart from the panel's findings that the appellant is suffering from a complex form of PTSD which in the opinion of Professor Katona would only be caused by some kind of repetitive inter-personal cruelty of the kind related to him by the Appellant who had been a child soldier. He suffers from complex PTSD. The panel found there was at least a risk that an adverse decision would lead to a suicide attempt although there had been no history of self-harm. Whilst in the UK the Appellant would have access to professional mental health support and there would be no reason to doubt that the respondent would make suitable arrangements for his protection on the return journey in accordance with her policy. We also accept the finding, based on Ms Wolfe's opinion, that returning him to the place where he suffered the trauma would be likely to place him at even higher risk.
35. In addition, drawing on the oral evidence given by Professor Katona, we find that, since the hearing before the panel there has been a modest but significant and continuing improvement in the appellant's depression but not his symptoms of PTSD. As it is not clear from the findings of the panel we record that he is suffering from depression as well as complex PTSD. He is nowhere near a full recovery. If he became aware that he was about to be returned to Liberia the prospect would terrify him exacerbated by the prospect of the cessation of his therapy and breaking off contact with those who have been supporting him. His depression and PTSD would become worse. We accept Professor Katona's evidence that the three main obstacles to returning to Liberia and fending for himself would be the likely deterioration in his mental health, the difficulty in accessing such mental health facilities as exist in Liberia and the problem of distrusting people there, particularly those in authority. His medication, Mirtazapine (an antidepressant), which is a relatively safe drug is less important than access to therapy and not a complete treatment on its own. In Professor Katona's opinion he should be clinically monitored, which would not have to be by a psychiatrist but could be by a GP or trained nurse.
36. Professor Katona has not seen any major setback in the appellant after past immigration decisions and is not aware that he has ever been hospitalised. He believed that the appellant worked at the Nissan plant near Newcastle and more recently has been working as a part-time kitchen porter. His ability to work in this country would, up to a point, help him in Liberia.
37. We need to update the finding as to the risk of suicide reached by the panel who found that there was "at least a risk that an adverse decision would lead to a suicide attempt although there has been no history of self-harm". Professor Katona was not aware that the appellant had ever attempted to commit suicide. His strong suicidal thoughts had diminished since 2012. Professor Katona's view as to the current risk of suicide was, he accepted, "informed speculation". He accepted that the best indication of the risk of

completed suicide was a previous attempt but the lack of a previous attempt was not a strong indication of a lack of risk. We accept his view that the appellant is not currently at high risk of committing suicide although the risk of increased suicidal thoughts will increase if he faces the prospect of imminent return.

Assessment of country conditions and medical facilities in Liberia

38. The evidence of Dr Harris is part expert psychiatric evidence part country evidence as to mental health treatment in Liberia with the greater emphasis on the latter because he is based in Liberia and has not seen or interviewed the appellant. We have reports from him dated 15 May 2012, 12 December 2013 and 29 January 2014. As the video link by which it was intended that he should give oral evidence was unsuccessful we also have the written questions posed by the respondent with his answers and the written questions posed by the appellant with his answers. He qualified as a doctor in Liberia and in psychology in England. He is registered as a medical practitioner in Liberia and in the UK. He is an associate professor of psychiatry at the College of Medicine at the University of Liberia. He is working as a psychiatrist in Liberia operating an outpatient mental health service in Monrovia. We find that he is well qualified to express his opinions to which we give considerable weight.
39. Dr Harris is currently the only fully qualified psychiatrist practising in Liberia which is a country with a population of approximately 3.5 million. There was another qualified psychiatrist but he has left the country. We find that there is only one "Wellness Centre" for the treatment of mental illness in Liberia, in Gbarnga, and the psychiatrist who worked there is the one who has since left the country. Since then it has been managed by a nurse with informal training. There is at least one mental health clinician in each county of the country. These are nurses who have undergone approximately a five-month training programme in the recognition and management of uncomplicated mental disorders at a basic level. There is only one hospital offering mental health facilities in Liberia, the E S Grant Mental Hospital in Monrovia, where Dr Harris works as a part-time consultant. The country has no formal special support services able to respond to crisis situations or able to provide support to individuals at high risk of suicide. Mental health services in the country are "extremely basic at best". Without employment or family support those with mental health issues have to fend for themselves and the appellant would not be able to obtain adequate psychiatric management and support in Liberia. In Dr Harris' opinion he is unlikely to be employable. Unless he is employed or has significant family support in Liberia he is likely to become destitute. His mental health is likely to deteriorate significantly.
40. In one report Dr Harris expressed the view that misunderstandings about mental disorders and stigma associated with mental illness were widespread and pervasive in Liberia. "Those with severe mental illnesses may be seen roaming about the streets of the capital city in deplorable physical condition,

sometimes half naked". There was a tendency to blame individuals for their illness and to ostracise and ridicule individuals who are mentally ill. People with some types of mental illness were sometimes believed to be demon possessed. However, we accept Dr Harris clarification in post hearing questions and answers that a person such as the appellant suffering from complex PTSD and depression would be unlikely to manifest the range of symptoms and behaviours which would result in his behaving in this way or result in ostracism, being treated as demon possessed or involved in substance abuse. He would not be classified as suffering from a psychotic illness even though he might manifest some psychotic symptoms.

41. We accept Dr Harris opinion that conditions for and treatment of the mentally ill in Liberia have improved and are continuing to improve since the war in that country and that the Government have made rehabilitation of healthcare facilities and reviving the healthcare sector a priority but subject to his caveat that there is still a long way to go. He does not accept the suggestion that there has been a dramatic increase in mental health care access across Liberia taking the view, which we accept, that access to facilities staffed by those who have some basic training in mental health diagnosis and management has improved but that this does not necessarily correlate to a general improvement in mental health care the quality of which still leaves much to be desired. There is still a basic lack of resources for the management of the mentally ill in Liberia.
42. Dr Harris evidence is that there was no provision for mental health services in the government's 2013 budget and only US\$25,000 in the 2014 budget. He accepts that approximately 44% of the adult population in Liberia suffers from symptoms of PTSD and that large numbers suffer from a Major Depressive Disorder. In this respect the appellant would not be worse off than a large proportion of the population. Whilst those offering the limited mental health treatment facilities available are likely to have encountered these illnesses it does not mean that they are experts in treating them. Any treatment which the appellant would be able to access would be basic and rudimentary. Unless, through friends, family or employment he had the funds he would find it difficult to access medication. As to the drug currently being taken by the appellant, Mirtazapine, Dr Harris latest evidence is that it is not available at the hospital where he is a part-time consultant but that it can be obtained on prescription from one pharmacy in Monrovia. In the light of Dr Harris evidence we find that such medication would have to be paid for unless the appellant was able to obtain help from a very charitable donor, which would be unlikely.
43. Dr Harris has amplified his previously expressed opinions and is now of the view, which we accept, that unless the appellant obtains employment or has significant family support he is likely to become destitute in Liberia. He points out that social adjustments for those returning to the country are difficult in the best of circumstances and that in the absence of supportive social

relationships forced return to an environment of previously experienced trauma may itself be traumatic.

44. We have studied the voluminous country information put before us which has provided a helpful context for the opinions expressed by Dr Harris. Having done so we accept his opinions as the best, most accurate and up-to-date information as to the situation facing the appellant were he now to return to Liberia particularly in relation to his mental health and mental health treatment in Liberia.

Discussion

45. In order to show that he is entitled to asylum it is for the appellant to establish, to the standard of a reasonable likelihood or a real risk that he faces persecution for a Convention reason in the country to which it is proposed to return him. His argument is that he would face social ostracism and stigmatisation, destitution and homelessness and harmful “spiritual” treatment for “demonic possession”.
46. It is also argued that the appellant would face persecution for a Convention reason as a member of a particular social group namely “mentally ill people”.

47. Applying Article 10 (1) (d) of the Qualification Directive;

“A group shall be considered to form a particular social group where in particular:

- i. Members of that group share an innate characteristic, or a common background that cannot be changed, or share a characteristic or belief that is so fundamental to identity or conscience that a person should not be forced to announce it, and
- ii. That group has a distinct identity in the relevant country, because it is perceived as being different by the surrounding society...”

48. Either but not necessarily both of these criteria need to be met (K and Fornah v SSHD [2007] 1 AC 412). Not all members of the group need to be at risk of persecution and it is no bar to asylum status that there is more than one reason for the persecution. There has to be a causal relationship between membership of the group and the feared persecution.

49. We do not accept that mental illness is an innate characteristic which is unchangeable in the sense that it is beyond the sufferer’s power to change it. It can be changed by treatment, whether or not the sufferer seeks this. It may well change over time without treatment. There is a valid comparison with physical illness; neither can be said to be unchangeable. Some mental illnesses may be long-lasting, some may come and go and others may be of short duration. There are many types of mental illness just as there are many types of physical illness. A group defined as “mentally ill people”, even in the context of a particular country such as Liberia, is too vague and ill-defined to identify those who might belong to it. It does not have a distinct identity. Whilst those with obvious symptoms of some types of mental illness might be

identifiable that will not be the case for all individuals and all types of mental illness. We find that the appellant has not established that he belongs to a particular social group or, as a result, that there is a Convention reason.

50. Article 3 of the European Convention of Human Rights is in absolute terms: "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". It is common ground that there is a high threshold in cases which raise mental or physical illness as a reason for challenging removal and that this threshold is particularly high in "foreign" cases such as this. Article 3 does not require a Contracting State to undertake the obligation of providing aliens indefinitely with medical treatment social and other forms of assistance lacking in their home countries. Lord Hope in (N v UK (2008) 47 EHRR 39) concluded that a case which might succeed would be one involving removal to "a place which lacked the medical and social services which (the applicant) would need to prevent acute suffering while he is dying".
51. The starting point is whether there are exceptional circumstances which would render an individual's removal a violation of Article 3 (D v UK (1997) 25 EHRR 423). In addition to an individual's medical condition exceptional circumstances can include conditions which that individual would face on return if they undermine his basic human dignity such as homelessness and destitution. The humanitarian grounds against the removal need to be compelling (N v UK). An assessment of an individual's circumstances in the country of return is required, focusing on the practical availability of the treatment or care rather than its theoretical availability. The assessment should be of the current situation in the receiving country as opposed to any questions of improvement or deterioration over a period. We accept that serious illness includes either or both of physical and mental illness (Pretty v UK (2002) 35 EHRR), MP (Sri Lanka) and NT (Sri Lanka) v SSHD [2014] EWCA Civ 829 and AJ (Liberia) [2006] EWCA Civ 1736 (at paragraph 12).
52. In GS and EO (Article 3 - health cases) (India) [2012] UKUT 00397 (IAC) a Presidential panel of the Upper Tribunal accepted that the ratio derived from the leading cases in relation to an individual suffering from a naturally occurring illness was whether the conditions which would meet that individual on return would undermine their basic human dignity. The imminent prospect of death could be part of the central question but cases which might succeed were not limited to individuals who were terminally ill. The cumulative effect of serious illness together with lack of medical care or family or social support might bring a case to the requisite high threshold. However, on the facts of that case it was held that the fact that life expectancy was dramatically shortened by the withdrawal of medical treatment in the host state was not capable of amounting to the highly exceptional case that engaged Article 3. The Tribunal did not make any findings in relation to the consequences of removal of a person with mental rather than physical illness including cases where the risk on removal was that of suicide. The panel was not referred to any suicide cases which had been considered by the Strasbourg Court.

53. In J v SSHD [2005] EWCA Civ 629 the Court of Appeal held that there was not a different test in cases where the Article 3 breach relied on was a risk of suicide or other self-harm. Counsel's submission that there should be a different approach from that established by the Strasberg jurisprudence in cases where there was a claimed risk of suicide was rejected. It was important to consider whether the claimed fear of ill-treatment in the receiving state on which the risk of suicide was said to be based was objectively well founded. In this context it was relevant to consider whether the removing or receiving states had effective mechanisms to reduce the risk of suicide.
54. The Court of Appeal in MP and NT agreed that "risk of suicide" cases fell within the same class as Article 3 ill-health cases generally.
55. An individual who succeeds on Article 3 grounds by reason of his mental health, risk of suicide or homelessness and degradation is not on that basis alone entitled to a grant of humanitarian protection. In MP and NT at paragraph 48 Maurice Kay LJ indicated that the two types of protection were not completely coextensive. The Qualification Directive was not intended to catch Article 3 cases where the risk was to health or of suicide rather than of persecution. N v UK made it clear that the difference was that the alleged harm would not emanate from the intentional acts or omissions of public authorities or non-state bodies but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country. In MP and NT it was not accepted that the Sri Lankan authorities were responsible for the claimant's mental ill-health and suicide risk.

Application to this appeal

56. In his claim for asylum the appellant's position is that he would face social ostracism and stigmatisation, destitution and homelessness and harmful "spiritual" treatment for "demonic possession". This relies on an interpretation of what was said in one of Dr Harris' reports which has been clarified since it was first expressed. Dr Harris' current opinion is that a person such as the appellant suffering from complex PTSD and depression would be unlikely to manifest the range of symptoms and behaviours which would result in his behaving in this way or result in ostracism, being treated as demon possessed or involved in substance abuse. He would not be classified as suffering from a psychotic illness even though he might manifest some psychotic symptoms. He would not come within the group of "those with severe mental illnesses (who) may be seen roaming about the streets of the capital city in deplorable physical condition, sometimes half naked", those who have been known to be chained or attached to logs or those who are seriously ill treated because of a perception of their mental ill-health.

57. Even if he were to be homeless and destitute or suffer some discrimination we find that the appellant has not established that the way in which he would be treated on return to Liberia would amount to persecution. Furthermore, there would be no Convention reason. For the reasons we have given the appellant is not a member of a particular social group.
58. In relation to the Article 3 grounds the appellant is suffering from depression and a complex form of PTSD caused by some kind of repetitive inter-personal cruelty suffered by him before he left Liberia much of it relating to his having been a child soldier. Since the hearing before the panel there has been a modest but significant and continuing improvement in his depression but not his symptoms of PTSD. He is nowhere near a full recovery. He continues to receive counselling and is taking Mirtazapine. If he became aware that he was about to be returned to Liberia the prospect would terrify him exacerbated by the prospect of the cessation of his therapy and breaking off contact with those who have been supporting him. His depression and PTSD are likely to become worse.
59. We accept Professor Katona's opinion that the appellant's medication, Mirtazapine, which is a relatively safe antidepressant drug, is less important than access to therapy and is not a complete treatment on its own. Mirtazapine is only available from one pharmacy in Monrovia and has to be paid for. It is not likely that the appellant would have the means to acquire this. We accept Professor Katona's opinion that the appellant should be clinically monitored in Liberia, which would not have to be by a psychiatrist but could be by a GP or trained nurse. We find that whilst the appellant would not have access to counselling, which has also been referred to as individually focused therapy, he could have some access to a nurse with mental health training. Dr Harris evidence was that there were a limited number of trained nurses throughout the country.
60. The panel found and we accept it is still the case that the appellant has no family in Liberia to help or support him. Such help and support would be very important in assisting him to resettle in Liberia and to obtain a job. Without support or a job he is likely to suffer a deterioration in his mental health, a lack of accommodation and destitution. We note that his mental ill-health has not made him incapable of working in this country. He worked at the Nissan car plant near Newcastle for several months and was a team leader in the packaging area. Subsequently he has been working as a part-time kitchen porter. We accept that he would find it difficult to obtain employment in Liberia. We have not been told and are not able to take into account any resettlement arrangements or payments which the respondent might provide.
61. As to the risk of suicide, Professor Katona was not aware that the appellant had ever attempted to commit suicide. His strong suicidal thoughts had diminished since 2012. Professor Katona's view as to the current risk of suicide was, he accepted, "informed speculation". The best indication of the risk of completed suicide was a previous attempt but the lack of a previous

attempt was not a strong indication of a lack of risk. We accept his view that the appellant is not currently at high risk of committing suicide although the risk of increased suicidal thoughts will increase if he faces the prospect of imminent return to the country where he suffered the trauma which has caused his current mental ill-health. Whilst in the UK the Appellant would have access to professional mental health support and there is no reason to doubt that the respondent would make suitable arrangements for his protection during the process of his return in accordance with her policy.

62. On his return to Liberia the appellant will not have access to specialist or dedicated treatment for suicidal ideation but he can have access to a clinic with a nurse who has limited mental health treatment training. Whilst there is a real risk that, lacking family support, the appellant would become destitute we are not persuaded there is a real risk that he will commit suicide. His mental ill-health, even if it deteriorates because he is forced to return to Liberia, is not otherwise life-threatening.
63. We must assess the risks of persecution or infringement of the appellant's Article 3 human rights on the basis of a current return to Liberia. However, the appellant's mental health is reasonably likely to be conditioned by his knowledge that his appeal has already succeeded on Article 8 human rights grounds and that he has been granted leave to remain in the UK for a period expiring in March 2015. He will know that he can make a further application for leave on Article 8 grounds before his current leave expires which will succeed or fail largely on the state of his mental health and conditions in Liberia at that time.
64. We are not persuaded that, looking at all the evidence relating to him and to Liberia, the appellant has established that on return to that country his mental ill-health will reach the very high threshold required for Article 3 foreign cases even when combined with the real risks of homelessness and destitution.
65. In relation to humanitarian protection we find that the threshold is the same as that for Article 3. If, as we have concluded, the appellant fails on Article 3 grounds then he also fails in his claim for humanitarian protection. Furthermore, he also fails because we do not accept that the Liberian authorities or any agents of persecution were responsible for any risks he faces.

Conclusions

66. In previous determinations there have been anonymity directions. In view of the state of the appellant's mental health we consider it necessary to continue the anonymity direction. We make an order under rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 prohibiting the disclosure or publication of any matter likely to lead members of the public to identify the appellant.

67. The appellant's appeal has already succeeded on Article 8 human rights grounds and that decision stands. We dismiss his appeal on Article 3 and humanitarian protection grounds.

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Signed
Upper Tribunal Judge Moulden

Date