



Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: PA/04889/2016

THE IMMIGRATION ACTS

Heard at Birmingham Employment
Tribunal
on 13 February 2019

Decision & Reasons promulgated
On 17 April 2019

Before

UPPER TRIBUNAL JUDGE HANSON

Between

JKW
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Miss H Foot, instructed by Binberg Peirce Solicitors
For the Respondent: Mrs H Aboni, Senior Home Office Presenting Officer

DECISION AND REASONS

1. Following a hearing at Birmingham on 15 October 2018 the Upper Tribunal found a judge the First-Tier Tribunal had erred in law such that the decision of that Tribunal was set aside, and directions given for a Resumed hearing to allow this Tribunal to substitute a decision to either allow or dismiss the appeal.

Background

2. At the outset of the Resumed hearing Miss Foot confirmed the appellant pursues a protection claim on the basis she is a member of a Particular Social Group (PSG) as a disabled person in Kenya, pursuant to paragraph 276ADE of the Immigration Rules on the basis of insurmountable obstacles to her reintegrating into Kenya, and article 8 ECHR.
3. Notwithstanding clear directions regarding the timescale for the provision of additional evidence and a debarring provision that evidence not filed in accordance with the directions would not be admissible without the express permission of the Upper Tribunal, Miss Foot mentioned additional evidence at the outset that she intended to introduce by way of supplementary questions. The directions provided that witness statements stood as the evidence in chief with the witness being made available for the purposes of cross-examination and re-examination only. There was no explanation for the failure to provide up-to-date witness statements especially in light of the representatives having requested an extension of the time period set out in the directions which was granted by a Lawyer of the Upper Tribunal on 26 November 2018, providing a further two weeks to enable the appellant to comply.
4. Additional witness statements were drafted at court from the appellant and her husband [RE]. Copies were provided to Mrs Aboni upon completion who confirmed she was not prejudiced by their introduction. The additional statements were therefore admitted.
5. The appellant was initially subject to cross-examination. There was no re-examination and no re-examination of the appellant's husband after which submissions were received from the advocates.
6. The current factual position as it stood at the date of the hearing shows a material change and that on 2 February 2019 the appellant moved into a new flat with her husband whom she has married. This is a housing association flat rented from Waterloo Housing which is an open plan spacious living space which they are in the process of making suitable for the appellant's needs. The appellant stated the central heating and cooking are electric which reduces any risk of her leaning on a gas cooker which she has done before. The applicant also claims she still requires use of all the equipment described in her earlier witness statement. There is a reference at [59] to an earlier undated witness statement appearing at page 39 of the appellants Upper Tribunal bundle in the following terms:

59. In addition to the above, I have also had a lot of support from an organisation named Vista, a charity that helps blind people specifically. I have a rehabilitation officer named Fiona Hind who is from Vista and she used to visit me every week until very recently. Vista provided me with support immediately after I became blind and they showed me how to live my life as a blind person. Fiona has given me lessons on technical skills around my house, how to type and lessons on using Velcro around my home to show me the end of

my fridge door or where the kettle is. This is helpful for me to go about my day-to-day life. She has started from scratch and teach me things like walking with my stick, how to cross the road and how to eat. With Fiona's help, I can now travel to hospital appointments alone from my house as I have learnt the route and the buses I need to take. This was not an easy thing to learn and I got lost many times in the beginning, when I first moved to my current address. They have also given me important props which I use in my day-to-day life such as binoculars, walking stick, magnifying glass and TV magnifier. Vista also provided me with a computer mouse magnifier in the past to allow me to read paper documents in a magnified form on a computer screen. Fiona really helped lift my spirits when I became blind. I was feeling deflated and depressed and she helped me to believe in myself and see that I could continue to do many of the things I did before, when I had sight.

7. The appellant claims to need a particular type of light bulb to mimic natural daylight which has been installed in the flat. The appellant claims her husband also helps her to get around the flat and tells her the colour of objects which helps of ensure she is dressed correctly; claiming that she might put on odd slippers or shoes if she does not get help. The appellant claims to need the same level of support described in her previous statement when she goes out, for example if her husband cannot go to church with her her friend needs to come with her. The appellant claims if she is in an unfamiliar place she will become anxious and explained she has particular routes she needs to follow, or she will get lost. The appellant claims she recently got out on an unfamiliar route going home and had to call her husband who explained to her over the telephone where she was and how to get home. In terms of her mental health the appellant claims she is taking Sertraline, 100 milligrams tablet a day, and also receives cream for use on a rash on her skin which is a side effect of the chemotherapy regime. The appellant claims in terms of her leukaemia she has regular reviews with her GP for checkups. The appellant no longer receives counselling from a community nurse from the Leicester General Hospital but has been advised by the counsellor to use her time with her younger sister [J] as therapy which the appellant refers to as her "happy place".
8. The witness statement from the appellant's husband [RE] confirms he is currently employed by three different employers from which he receives £16,800 per annum net which equates to £1400 per month net from which he supports himself and the appellant. At [4 - 6] [RE] writes:

4. If [J] was sent back to Kenya in all honesty, I do not think I would be able to go with her. I do not believe our relationship would survive in Kenya. I have family and support here and I am a British citizen. I do not think I would be able to support [J] in Kenya, given how much of a struggle day-to-day life will be for me as well as for her.

5. We do not even know if I would be able to get a Visa to live there.
6. In terms of [J] vision and her day-to-day needs, I don't think she gives herself enough room for error. I don't think she is cautious enough and I think she underestimates her limitations. This is partly a good thing, because it has driven her to achieve a lot, and this makes her feel good about herself. But I think she puts herself under great strain. I also think optimism can be a risk to her because she underestimates her weaknesses and is not always good at asking for help.
9. The medical evidence is set out at the appellant's appeal bundle between [157-238]. The most recent correspondence is that dated 26 June 2017 composed of a medical legal report from Dr Mary Robertson, a Chartered and Consultant Clinical Psychologist, a letter from Dr Tyadellis an Ophthalmology Registrar from the University of Hospitals of Leicester NHS Trust and a letter from Dr Bhuller a Consultant in Paediatric, Teenage and Young Adult Haematology also from the University Hospitals of Leicester NHS Trust.
10. Dr Robertson was, in addition to undertaking a diagnosis, asked a number of questions by the appellant's advocates. The Opinion and Recommendations section of Dr Robertson's report is set out at Appendix A below.
11. There is reference in the medical evidence to the stigma that the appellant feels she will be the victim of if returned to Kenya. The appellant relies on a report from her country expert Dr Kodi dated 5 July 2017 found at pages 43 – 52 of Section B of the appellant's appeal bundle. The appellant is a member of the Agikuyu, also known as Kikuyu, who Dr Kodi states are one of the largest of about 40 ethnic groups in Kenya making up about 22% of the population and playing a dominant role in all sectors of the economy and who are renowned for their entrepreneurship. Dr Kodi states, however, that the Agikuyu consider somebody who had been diagnosed with leukaemia or who had disability, such as blindness, to be cursed, a view that is widely shared and found in other ethnic groups in Kenya. It is also the expert's opinion that family members will be ashamed to have a relative with her disability and would be likely to shun the appellant rather than associate with her and that she will be considered a burden on her relatives. Dr Kodi states it is unlikely family will be willing to pay for her medical treatment if she needed it which it is said could possibly explain why the appellant's family in Kenya have not made contact with her since hearing she had been diagnosed with leukaemia. Dr Kodi's opinion is that it was unlikely that people of Agikuyu background outside the appellant's family will assist a blind person in Kenya and that as she will be considered a burden on society the appellant will not be able to make friends and form relationships.
12. In relation to availability of medical care, Dr Kodi refers to the evidence calling for very specialised and regular care that the appellant is unlikely to access through the national healthcare service of Kenya as a result of lack of availability of treatment and highly trained personnel as well as stigma attached to her condition as a blind person. Dr Kodi noted the shortage of health

personnel continued to affect services in Kenya referring to poor working conditions and doctors striking over low pay.

13. In relation to the available services, Dr Kodi refers to a number of organisations that provide assistance to the blind such as the Kenyan Society for the Blind which is said to be underfunded and overstretched. Most funding coming from foreign aid. Dr Kodi refers to data indicating there are more than 250,000 blind people in Kenya most of whom are in need of assistance and that deprived of such assistance struggling families have no choice but to marginalise their deaf/blind children. It is Dr Kodi's opinion that the Kenyan Society for Blind or any other organisation will be unlikely to take up a new and complex case such as that of the appellant.
14. In relation to return as a single woman, Dr Kodi states the appellant will be quite vulnerable and could be taken advantage of by malevolent individuals. She will be in grave danger of being mistreated and even raped. Rape of young women and girls is a serious problem throughout Kenya including in rural areas with at least 300 cases of rape reported every day in Kenya although the actual number of unreported rapes is unknown. Dr Kodi believes it is unlikely the appellant will be able to access education, employment, and housing, without family support which she will not have. Dr Kodi believes it is unlikely with her disability the appellant could compete with the thousands of able-bodied and highly educated young people seeking jobs for reasons which were identified as limiting opportunities due to social rejection, discriminatory employment practices, architectural barriers and inaccessibility of transport. Dr Kodi states relocation would not be a means to solve the problems as the appellant would face the same prejudices in Nairobi and that things may be even worse for her in the countryside where people's views are more rooted in traditions and cultures which consider anybody with a disability as a cursed person who can bring misfortune to those who associated with him or her.

Discussion

15. The appellant claims a grant of international protection by way of refugee status on the basis of persecution as a disabled person in Kenya and therefore a member of a Particular Social Group (PSG).
16. In *Minister voor Immigratie en Aisiel v X, Y and Z* C-199/12 and C-201/12 CFEU Fourth Chamber it was held that the definition of "a particular social group" in Article 10(1) of the Qualification Directive required that two conditions were met. First, members of such a group had to share an innate characteristic or belief, so fundamental to identity or conscience that they should not be forced to renounce it. Secondly, it was necessary for the group to possess a distinct identity in the relevant country because members were perceived as different by the surrounding society.
17. In *SSHD v K and Fornah v SSHD* [2006] UKHL 46 Lord Bingham derived the following principles from the legal authorities, including the Qualification Directive. (1) The Refugee Convention was not concerned with all cases of discrimination, only with persecution based on discrimination, the making of

distinctions which principles of fundamental human rights regarded as inconsistent with the right of every human being. (2) To identify a social group the society of which it formed part had to first be identified; a particular social group might be recognisable as such in one country but not in another. (3) A social group need not be cohesive to be recognised as such. (4) There could only be a particular social group if it existed independently of the persecution to which it was subject.

18. It was not submitted on the respondent's behalf that the appellant did not belong to the suggested PSG but rather that even if the appellant's medical disability was accepted she will not experience ill-treatment sufficient to amount to persecution due to this.
19. The Refugee or Person in Need of International Protection (Qualification) Regulations 2006. Regulation 5(1) states:

"In deciding whether a person is a refugee an act of persecution must be:

- (a) sufficiently serious by its nature or repetition as to constitute a severe violation of a basic human right, in particular a right from which derogation cannot be made under Article 15 of the Convention for the Protection of Human Rights and Fundamental Freedoms; or
- (b) an accumulation of various measures, including a violation of a human right which is sufficiently severe as to affect an individual in a similar manner as specified in (a).

(2) An act of persecution may, for example, take the form of:

- (a) an act of physical or mental violence, including an act of sexual violence;
- (b) a legal, administrative, police, or judicial measure which in itself is discriminatory or which is implemented in a discriminatory manner;
- (c) prosecution or punishment, which is disproportionate or discriminatory;
- (d) denial of judicial redress resulting in a disproportionate or discriminatory punishment;
- (e) prosecution or punishment for refusal to perform military service in a conflict, where performing military service would include crimes or acts falling under regulation 7.

(3) An act of persecution must be committed for at least one of the reasons in Article 1(A) of the Geneva Convention. "

20. In *Shah and Islam and Others v SSHD* HL (1999) INLR 144 Lord Hoffman said that the concept of discrimination in matters affecting fundamental rights and freedoms is central to an understanding of the Refugee Convention. It is concerned not with all cases of persecution, even if they involve denials of human rights, but with persecution that is based on discrimination.
21. The Secretary of State's position is that what the appellant identifies as the reality of life for her in Kenya, as a result of the issues referred to by Dr Kodi, is discrimination not sufficient to cross the threshold of persecution.

22. This is not a case involving past persecution for the appellant's illness only manifested itself in the United Kingdom with the blindness occurring as a result of the treatment the appellant received in the UK. It is not suggested the appellant will be subjected to direct persecution by the authorities in Kenya but that she may be shunned by members of her ethnic group and find it difficult if not impossible to re-establish herself through employment or education for the reasons identified in the expert report.
23. Two cases relevant to the issue of disability are *SHH v UK* Application 60367/10 EctHR (Fourth Section) in which the applicant claimed that as a disabled person he would be at risk in Afghanistan, being more susceptible to violence and homelessness. The court found that the difficulties for disabled people were not the fault of the Afghan authorities and that where the problems facing an applicant would be largely the result of inadequate social provision the approach adopted in *N* was the appropriate one. On the evidence the appeal was dismissed.
24. In *R(on the application of HN and SA)(Afghanistan [2016] EWCA Civ 123* the Claimants asserted on a JR application that they would be at risk as a result of the worsening security position in Afghanistan and also as vulnerable individuals – HN, by reason of mental health problems and SA by reason of being a former unaccompanied child. The Claimants' applications were dismissed.
25. I find the appellant has failed to discharge the burden of proof upon her to the required standard to establish she is entitled to be recognised as a refugee on the facts of this appeal. It is not disputed the appellant is likely to face discrimination, but it has not been made out this is of a systemic nature from the authorities or others from whom the authorities have been shown unwilling or unable to provide protection to the Horvath standard. Although the appellant is likely to face discrimination I do not find that it has been made out this will be systemic discrimination with the rights of disabled people not being sufficiently enforced such as to entitle the appellant to a grant of international protection.
26. In relation to the Immigration Rules, the respondent's case is that it was not accepted that very significant obstacles existed to the appellant's integration into Kenya. It is said the appellant claims to be dependent upon her husband, but he is not always with her and is working most of the day and that the appellant is able to function independently carrying on her private life whilst her husband is at work. This submission is relevant to the claim pursuant to paragraph 276ADE.
27. In *Treebhawon and Others (NIAA 2002 Part 5A – compelling circumstances test) [2017] UKUT 13 (IAC)* it was held that mere hardship, mere difficulty, mere hurdles, mere upheaval and mere inconvenience, even where multiplied, are unlikely to satisfy the test of "very significant obstacles" in paragraph 276 ADE of the Immigration Rules. In *Parveen v SSHD [2018] EWCA Civ 932* Underhill LJ commented on that observation " I have to say that I do not find that a very useful gloss on the words of the rule. It is fair enough to observe that the words "very significant" connote an "elevated" threshold, and I have no difficulty with the observation that the test will not be met by "mere inconvenience or

upheaval". But I am not sure that saying that "mere" hardship or difficulty or hurdles, even if multiplied, will not "generally" suffice adds anything of substance. The task of the Secretary of State, or the Tribunal, in any given case is simply to assess the obstacles to integration relied on, whether characterised as hardship or difficulty or anything else, and to decide whether they regard them as "very significant".

28. In this case it is necessary, when considering this element, to consider how all the pieces of the evidential jigsaw link together. The appellant left Kenya as a young person to come to the United Kingdom in good health. Her experiences of living within Kenya are of living within her family and tribal unit with, despite her mother fleeing, the appellant having a secure foundation in which to grow and develop. The appellant came to the United Kingdom lawfully in what was believed at the time to be good health. Within the United Kingdom her life completely changed when she was diagnosed, again as a young person, with leukaemia for which she received treatment on the NHS which has been successful. The appellant has now received the "all clear" which medical professionals will not give an individual suffering from any form of cancer until an appropriate period has passed since the end of their treatment and there has been no obvious sign of leukaemia/cancer recurring. During the course of the appellant's treatment, as a result of the chemotherapy she received, the appellant lost her sight. Ocular toxicity induced by cancer chemotherapy includes a broad spectrum of disorders, reflecting the unique anatomical, physiological and biochemical features of the eye one of the consequences of which is loss of sight. Fortunately for the appellant, and contrary to the earlier reports, the appellant has recovered some sight but is not likely to recover all the vision that she previously enjoyed. The appellant has, understandingly, in addition to the physical aspects of her illness and treatment suffered considerable psychological and emotional trauma as identified in the report of Dr Robertson. Whilst developments since the report was written have been encouraging it is not a case that any of the experts say without hesitation that the appellant is unaffected by what has occurred to her and, in terms of mental health issues, or that returning the appellant would not have a negative impact.
29. The Secretary of State's case is that there will be no difficulties the appellant is unable to overcome if she is returned to Kenya. Although the appellant has recently married it appears to be the case that if returned the appellant will not have the benefit of her husband's support and unlikely to have the support of her family or members of her tribal group for the reasons established by Dr Kodi. It also appears to be the case that the Kenyan Society for the Blind and other NGOs will hesitate in providing assistance as a result of pressures on resources, lack of available resources, and complexity issues. Dr Kodi is of the view that as a result the reality for the appellant on return is that she will be without support.
30. There is clear evidence of obstacles that the appellant will face to her reintegration into Kenya and whether these are obstacles that she will be able to overcome requires a careful subjective analysis. It is not made out the appellant will be able to change the opinions of her family or tribal group who consider

her cursed as a result of her suffering cancer and blindness, even if on return she is now only partially sighted. I place weight upon the report of Dr Kodi that this will mean the appellant will effectively have to fend for herself in a country where she has not lived for a number of years and possibly in the capital city Nairobi. I accept that in the more rural areas the appellant may face further difficulties as a result of the more traditional entrenched view that the appellant is cursed as a result of the medical issues. The appellant has been consistent in her evidence that in such a situation she will not be able to cope. The psychological evidence is that the appellant's coping mechanisms require a structured routine and evidence from other sources is that she is able to lead the life with the degree of independence she currently has as a result of the fact it is enjoyed within a familiar environment where the appellant is reasonably certain where she is, where things are, and the ability to call for assistance if need arises. This is amply illustrated by the evidence of the appellant having to find a different route home, becoming lost and having to contact her husband for assistance.

31. It is not disputed the appellant is in remission and needs less input from the medical and support professionals as she has in the past, but that such support as she currently enjoys will not be present in Kenya. It is also the case that the appellant requires suitable accommodation to enable her to live a meaningful life and that without knowledge of day to day life in Kenya or support there is arguable merit in the appellant's contention that she will be unable to find or access such accommodation, will be unable to secure employment, or to pay for the same. There is also a material difference between the reality of life for a disabled person in the United Kingdom where advances in the understanding of society for the needs of the disabled and provision such as the Equality Act enable support to be available and prevent, as far as possible, discrimination and enable a person to lead as near normal a life as possible, and Kenya where the atmosphere from the public is hostile. It is also the situation, according to the psychological report, that the appellant requires emotional support from her mother, friends, mental health professionals, and others who have provided assistance to her to enable her to function at her best.
32. The Secretary of State does not dispute the submission that both family and private life rights are engaged in the United Kingdom recognised by article 8 and that the issue in the appeal is the proportionality of the appellant's return. Mrs Aboni submission on this point was that the appellant can return to Kenya where she can make an application for leave to remain in the United Kingdom under the Immigration Rules.
33. In *R (on the application of Chen) v SSHD (Appendix FM – Chikwamba – temporary separation – proportionality)* IJR [2015] UKUT 00189 (IAC) it was held that (i) Appendix FM does not include consideration of the question whether it would be disproportionate to expect an individual to return to his home country to make an entry clearance application to re-join family members in the U.K. There may be cases in which there are no insurmountable obstacles to family life being enjoyed outside the U.K. but where temporary separation to enable an individual to make an application for entry clearance may be disproportionate.

In all cases, it will be for the individual to place before the Secretary of State evidence that such temporary separation will interfere disproportionately with protected rights. It will not be enough to rely solely upon the case-law concerning *Chikwamba v SSHD* [2008] UKHL 40. (ii) Lord Brown was not laying down a legal test when he suggested in *Chikwamba* that requiring a claimant to make an application for entry clearance would only “comparatively rarely” be proportionate in a case involving children (per Burnett J, as he then was, in *R (Kotecha and Das v SSHD)* [2011] EWHC 2070 (Admin)). However, where a failure to comply in a particular capacity is the only issue so far as the Rules are concerned, that may well be an insufficient reason for refusing the case under Article 8 outside the rules.

34. It is not disputed there is a positive obligation upon the United Kingdom as Article 8 ECHR entails a positive obligation on the part of the state to protect the physical integrity of persons within their jurisdiction. It is not disputed this is a case where, in all likelihood, if the appellant applied for leave to re-enter she would succeed pursuant to Appendix FM and/or on human rights grounds. The appellant speaks English and is of independent means.
35. The protection of private life under article 8 ECHR encompasses a person’s physical and psychological integrity. A sound mental state is an important factor for the possibility to enjoy the right to private life (*Bensaid v UK* para 47).
36. The evidence on the Psychologist is that returning the appellant to Kenya will have a significant effect upon her mental health and ability to function particularly without the requisite support systems. Although I accept it may be possible for the appellant to take with her some of the portable items such as magnifying glasses, Velcro, and other items that she has used to facilitate the quality of life in the United Kingdom these only work if the environment in which the appellant is functioning is familiar to her; such as her home.
37. Considering the factors set out in section 117 of the 2002 Act and balancing the competing arguments in this case I find the appellant has made out that in the real world in which these matters need to be assessed and her lack of experience of living in Kenya in the circumstances in which she will now face on return without support of either family, tribal group, or external organisations committed to enabling her to re-establish herself and secure paid employment, issues of which she has no direct control, means this is one of the rare cases in which the appellant will face insurmountable obstacles to her reintegration into life in Kenya. Even if that finding was not accepted and the issue was the question of whether the decision is proportionate pursuant to article 8 ECHR, I find on the basis of the appellant’s physical and moral integrity, the respondent’s acceptance that return will be for the purposes of applying to re-enter with it not being shown the appellant would not succeed on such an application, that the impact of returning the appellant to Kenya, even during the period of time whilst an application was being made, will be so detrimental to her psychological well-being and possible exposure to risk of harm as identified to Dr Kodi, including rape or any other form of exploitation, that the respondent’s decision and resultant interference with the appellant’s protected right to family and private life is not proportionate.

38. As there is no ground of appeal under the Immigration Rules I find the ground of appeal on which the appellant is able to succeed is the human rights grounds and, accordingly, allow the appeal pursuant to article 8 ECHR for the reasons set out above.

Decision

39. **I remake the decision as follows. This appeal is allowed.**

Signed.....
Upper Tribunal Judge Hanson

Dated the 11 April 2019

Appendix A

17. **Assessment of [K] current psychological state setting out any directly observed symptoms of possible as well as any self-reported symptoms.**
 - 17.1 For a diagnosis of Major Depressive Disorder in the severe range. As outlined in paragraph 14.1 – 14.5 [K] also meets criteria for an Adjustment Disorder with mixed anxiety and depression. However, given the duration and severity of her symptoms, I am of the view that she has reached the threshold for a primary diagnosis of Major Depressive Disorder.
 - 17.2 [K] also meets criteria for a diagnosis of Panic Disorder. A detailed description of symptoms and how I have reached my conclusions is outlined in this report. Her symptoms have a significant impact on her day-to-day functioning and interpersonal relationships.
 - 17.3 [K's] symptoms began after she was diagnosed with cancer and was rendered blind due to complications from chemotherapy treatment. She describes no history of mental health difficulties prior to these events. In my opinion, the uncertainty regarding her future and her fear of returning to Ken year is exasperating her symptoms. Much of her anxiety about return relates to her sense of vulnerability due to her visual impairment and how she would adapt in an unfamiliar environment without support and her worries about her health.
 - 17.4 [K] presentation, self-report and results on standardised assessment tools are all consistent with her diagnosis. She gave a reasonable account of her current difficulties in the relationship between her reported history and current difficulties was reasonable. I have considered whether [K] is malingering and I do not believe this to be the case.
18. **What treatment/medication would assist [K]**
 - 18.1 The evidence base for the treatment of adjustment disorder is limited (Casey and Bailey, 2011) with brief therapy is usually recommended. These include individual psychotherapy, family therapy, behaviour therapy and self-help groups. The primary goal of treatment is to relieve symptoms and help the person achieve a level of functioning comparable to that prior to the stressful event. Social support in the form of friends, family and the community are usually prioritised. In addition the individuals coping, and problem-solving skills are explored and developed and the individual is assisted in finding ways of adapting to and coping with the stress or. Relaxation techniques are also helpful in dealing with stress and anxiety.
 - 18.2 When medication is used, it is typically in addition to psychotherapy. Prescription medication may be helpful in easing the depression or the anxiety associated with adjustment disorder. However, treatment of adjustment disorder usually excludes use of medication.
 - 18.3 Most people recover from adjustment disorder without any remaining symptoms if they have no previous history of mental illness and have access to stable social support. Individuals suffering from adjustment disorder should work to develop and maintain a healthy diet and sleep patterns, as well as a strong social support system.
 - 18.4 In my opinion, [K] has been receiving the appropriate treatment for her adjustment disorder. Her participation in groups with other young cancer survivors and the support she receives from her cancer network, family and friends has played a vital role in managing her mental state. I have commented on this further in this report. She is also

receiving counselling from a community psychiatric nurse with a focus on teaching her relaxation skills and mindfulness. The support she is receiving from Vista has been central to her learning to cope with and adapt to her disability.

- 18.4 Adjustment disorders are associated with high risk of suicide and suicidal behaviour, substance abuse, and the prolongation of other medical disorders or interference with their treatment. Adjustment disorder that persists may progress to become a more severe mental disorder, such as major depressive disorder. As already stated, I am of the opinion that this may be the case for [K] I would therefore recommend more intensive treatment for her depression in addition to the support she is already receiving.
- 18.5 Recommended treatment for Major Depressive Disorder with moderate or severe depression is a combination of antidepressant medication and Cognitive Behaviour Therapy or Interpersonal Therapy (NICE guidelines, 2010). [K] is already taking a high dose of antidepressant medication. In addition to this I would recommend that she is referred to her local psychology service for a course of CBT or IPT addressing her depressive symptoms and her panic attacks. I am of the opinion that she requires a more intensive psychological intervention than she currently receives from her community psychiatric nurse in the Psycho-Oncology Service.
- 18.6 [K] symptoms are severe and are unlikely to improve without the appropriate evidence-based psychological treatment and support. Without the appropriate treatment of symptoms are likely to interfere with her social and occupational functioning for the foreseeable future.
- 18.7 I am hopeful that with the appropriate specialist treatment, [K] will make clinically significant recovery. However, it is likely that she will remain vulnerable to deterioration if exposed to further stress also will require continued monitoring in such circumstances.
19. **If [K] were to be told for certain that she had to return to Kenya would she suffer psychological consequences; and if so, what consequences would she suffer - in particular please comment on whether she would become delusional or suicidal, will she harm herself, if so how seriously, and would she succeed in killing herself.**
- 19.1 In my opinion, being told that she had to return to Kenya would have a significant and detrimental impact on [K]'s mental health. She is highly anxious and fearful about this prospect and if this became a reality, her anxiety and fear would increase dramatically.
- 19.2 [K] has found it extremely difficult to adjust to her blindness and she is still in the process of learning to cope and adapt to her disability. She lacks confidence and skill in managing all aspects of her daily life and requires continued support and high levels of practical and emotional support from her mother, partner, social and professional network as I have outlined later.
- 19.3 A factor which has been helpful in her recovery is that she returned to Leicester which is a familiar environment. This made it somewhat easier for her to adapt. However, this would be very different if she returned to Kenya as she would have little familiarity with the environment which is likely to have changed in the 7 years since she has been away. She told me that she would fit like she was having to start again in a strange New World and in my view, this is a reasonable perception. [K] lost her sight in the UK and she has no experiences living as a blind person in Kenya.
- 19.4 [K] feels frightened and unsafe in unfamiliar environments and it is likely that her fear and anxiety will overwhelm her and interfere with her capacity to adjust and adapt to her life there. She told me that she does not know how she would manage to negotiate her way around the country as a blind person.

- 19.5 This will be further aggravated if she has no support service available. [K] believes that her relatives in Kenya would reject her because she had cancer and is now blind. She fears for her safety and believes that they would want to get rid of her as she is perceived to be "cursed".
- 19.6 Over the past 7 years [K] aunt has lost her business twice and she is now convinced that this is because of [K]. She blames [K] for her misfortune and has told her that she wants nothing to do with her and they no longer speak. Her aunt has maintained contact with her mother. She has told her mother that she has been warned that there would be further mishaps if she maintained contact with [K]. [K] believes that this is the reason why her aunt has cut contact with her and she said that she no longer tries to communicate with her aunt any more. She has also not spoken to her brother since 2015 and she has told me that he also believes that she has been cursed. [K] is very hurt and sad that her brother has rejected her.
- 19.7 She has no contact with her father and she believes that he would not want anything to do with her. She is unsure if he is still living in Kenya. She feels angry with her father who has never been there for her when she has needed him and she has no reason to believe that this will ever change.
- 19.8 As a result [K] believes that she would be isolated and alone if she returned to Kenya. She does not know what she would do or who she would ask for help and this makes her feel very scared and worried. She fears that she would end up begging on the street and she does not believe that anybody in Kenya would care about her or understand. She also believes that she would face humiliation and shame in the community would think very badly of someone who has gone abroad and returned destitute and alone. She believes that this will be perceived as confirmation that she is cursed.
- 19.9 [K] also worries that she will not be able to access the medical care and support she requires if returned and fears that she may relapse. She is not yet in remission and she worries about any new symptom and she frequently seeks reassurance from her Macmillan nurse. She has been told that she will be given priority access to any research trial targeting the damage to her optic nerve but she does not believe this would be available to her in Kenya. She told me that she would have to pay for her medical care in Kenya and without any source of income, this would not be possible. For these reasons, [K] anxiety about her health is likely to escalate if faced with the prospect of return. In addition any hope of a potential cure for her blindness will be dashed which will increase her sense of hopelessness.
- 19.10 I had no reason to doubt that [K] fear is genuine, whether or not it is objectively well-founded. Given [K] vulnerability and her current mental health difficulties, I do not believe she will have the emotional resources to cope with the increased fear and anxiety and that her mental state will further deteriorate. I note that this opinion is shared by her Senior Clinical Nurse Practitioner, Ms McDonald (letter dated 18 August 2016).
- 19.11 [K] will be faced with the prospect of losing her extensive support system in the UK if she was told she had to return. In my opinion, she would not be able to cope without this network as outlined later in this report. [K] told me how afraid she is of losing her relationship with her mother. She had to deal with the sudden loss of her mother when she was a child. I had the impression that this was very painful and difficult for her and at the time and left her feeling abandoned and alone. The reunion with her mother had been of major importance to her and despite many difficulties, she has worked very hard to rebuild her relationship with her mother and this is profoundly important to her. She is also very close to her baby sister and told me that "she is everything to me".

- 19.12 [K] relationship with her partner is also extremely important to her psychological well-being as outlined in this report. They are in the process of getting engaged and planning a future together. Her relationship with her partner, family and friends make her feel safe and secure. If she was faced with the potential loss of these relationships, I am in no doubt that [K] this loss would inevitably reactivate previous losses and feelings of abandonment.
- 19.13 [K] is very protective of her mother and she told me at several points how much she worries about her mother and does not want to retraumatise her given how much she has been through. She believes that if she returned to Kenya, her mother would suffer even further. [K] already feels guilty about being a burden to her mother and this guilt is likely to escalate if she faced return.
- 19.14 In my opinion the threat of return will leave [K] feeling helpless, fearful and hopeless. There is an extensive body of research literature on hopelessness (e.g. Beck et al., 1975), which is found that hopeless thoughts have been identified as the biggest risk factor in predicting suicidal behaviour in individuals with symptoms of depression. Suicide risk is also a significant risk of people with adjustment disorders. [K] sense of hopelessness will be exasperated by her belief that she will be rejected and stigmatised by her family and community and the fear that she will face hardship because of her blindness.
- 19.15 [K] presents with depression in the severe range. In my view her depression and anxiety will increase if told she has to return. She is not at current risk of suicide but this risk will significantly increase if her mental state deteriorates. She is likely to require close monitoring and psychiatric management of her mental state at all stages of the process. Crisis intervention and hospital admission may need to be considered in the event of more severe breakdown or increased suicide risk.
- 20 Whether I believe the current relationships/support network she has established in the UK are important for the maintenance of her mental health at this current level.**
- 20.1 In my opinion [K] support network and current relationships play a vital role in maintaining her mental health at this current level. This includes the large professional network involved in her care as well as her network of friends and close relationships with her family (mother and sister) and her partner to whom she is about to become engaged.
- 20.2 [K] is receiving support from her cancer team which includes a doctors as well as the Macmillan Cancer Support, Teenage Cancer Trust and CLIC Sargent charity for childhood Cancer support. She is also receiving regular psychological support in the Psycho-Oncology Service. In my opinion this professional network of support has been very important in helping [K] to deal with her illness and subsequent loss of vision and the multiple challenges and anxieties around this.
- 20.3 [K] attends a support group every month where she meets up with friends from the Teenage Cancer trust. She said that this is hugely helpful as she is among people who know and understand what she has been through. She said that she feels understood by them and knows they will not judge her. At these meetings they play games and have fun. They have also been on visits to places including Scotland, the Royal Albert Hall and Alton Towers. She said that they do something different every month. This group provides her with a space where she feels understood, supported and has fun.
- 20.4 Her social worker helps with paperwork such as completing forms or letters. Her youth worker from the teenage Cancer trust helps access social and fun activities. Her nurse from Macmillan helps her with medical related issues. [K] said she can call her whenever she needs to for advice or to ask questions. She attends counselling every 3 weeks with a

community psychiatric nurse which has helped to learn techniques to ground herself and manage her distress. [K] said that she finds it a relief to talk and to have a confidential space in which you can talk about things which she does not feel able to talk about her mother or her partner.

- 20.5 [K] has also received intensive support from Vista to help her adjust to her visual impairment. She has had significant difficulty adjusting to her visual impairment and the support from Vista has played an essential role in helping her adjust and develop her confidence to cope with her blindness. She has a close relationship with her support worker, Fiona, who has been an inspirational role model to her. The supporters enable her to learn to manage the many challenges he faces in carrying out daily tasks in her home and external environment (see paragraph 7.22). This support has decreased in intensity as [K] has become more able to manage her disability. However, I am of the opinion, that [K] is in need of continued support as she still feels insecure and afraid in certain situations including being in a new environment and environments with low light. She has not yet learned to cook independently without burning herself and requires further support in this area.
- 20.7 [K] has already had significant difficulty adjusting to her life threatening illness, intensive and invasive treatment and medical complications resulting in her loss of sight. [K] adjustment difficulties and her need for high levels of support his repeatedly noted in her medical records. She fell ill at a point in her life when she was a young adult in the process of building a life and the future for herself. In her words, her world crumbled when she fell ill and the loss of her site was even more devastating. She has been diagnosed with depression and an adjustment disorder as a result. In light of this, this professional support network has been both necessary and helpful in managing her distress without her deteriorating even further. [K] remains very anxious and vulnerable in relation to her health and blindness and is therefore in need of continued support until she is certain that she is in remission and she has fully adjusted to her blindness.
- 20.8 [K] mother and partner have also played a key role in helping her manage her day-to-day life. Her mother is very involved in her life and assists with her shopping, cleaning, cooking and other household tasks. [K] would be unable to manage without this practical support. Without this support, I do not believe that [K] would be able to live in her own flat.
- 20.9 This independent living is psychologically very important to [K]. She struggles with being dependent on other people. She worries that she is a burden on them and this leaves her feeling guilty and negative about herself. Her dependency also leaves her feeling vulnerable to being hurt or abandoned which is understandable given the losses she endured in her childhood. In my view, the fact that she can live on her own with this extra support from her mother has made a very, positive contribution to [K] well-being and sense of mastery and hope which are necessary for her recovery.
- 20.10 In addition to the practical support, the emotional support she gets from her mother is equally important. [K] described her mother as enormously supportive during her illness and she talked about how safe she felt when her mother was with her in the hospital when she was critically ill. Although their relationship has been difficult at times, they have both worked hard at improving this and have become closer as a result. This relationship is clearly a very important source of emotional support for [K] which has undoubtedly helped her cope.
- 20.11 [K] partner is also central to her mental well-being. They have been together for 3 years and are planning to get engaged. Despite [K] attempts to push her partner away when she has felt scared and afraid of being a burden to him (see paragraph 8.6), he has stuck by her. In my view her partner's commitment to her in the face of difficulty has helped

her to build trust and to feel safe. She feels that her partner and his family accept her for who she is. These factors are very important for [K] well-being in light of the rejection she has experienced from her family in Kenya and the abandonment by her father and the sense of abandonment she will have felt as a child when her mother had to flee Kenya.

- 20.12 In addition to the above-mentioned support, [K] has a close group of friends who she has known since before she was blind and with whom she feels safe. She feels good when she has contact with them and in my opinion, these relationships provide a helpful sense of connection to the person she was before she came blind and the space in which you can safely have fun and feel normal.
- 21. [K] has instructed that if you were to return to Kenya, she would have no family or social support due to the stigma associated with having had cancer/being blind. Please comment on how this would impact on her mental state.**
- 21.1 As already outlined, one of [K] main worries about being returned is the lack of support there due to the stigma associated with having had cancer and being blind. She would also learn loose a large and well-developed network of professionals, family and friends of return.
- 21.2 In my opinion this would have a profound impact on her mental health. Social support has been identified as a key factor in the recovery from depression and adjustment disorder. The harmful consequences of poor social support and the protective effects of having access to varied and functional social networks on maintaining physical and psychological health has been well documented (Ozbay et al 2007)
- 21.3 [K] is likely to become profoundly depressed, isolated and anxious if she has no family or social support upon return. Removing her from her existing networks of social support is likely to overwhelm her emotionally and will invariably result in a worsening of her symptoms. This is likely to impact on her ability to take the necessary steps to establish yourself in Kenya. It is also likely to be a barrier to her recovery and may have a detrimental impact on her physical health as well. In my view [K] will be at increased risk of suicide in the absence of social support.
- 21.4 In summary, I am of the opinion that [K] is a vulnerable young woman who is in need of continued emotional and practical support in order to manage her levels of mental distress and day-to-day life.
- 22 Comment on whether I believe her mental state impacts on her ability to take advantage of services on offer. Whether in the light of my assessment about what would happen if you were to be removed to Kenya to her mental health, I believe her ability to access services there would be affected**
- 22.1 [K] is accessing a wide range of services as previously outlined. Much of this support was initiated when she was ill with cancer. Her access to psychological support has been more recent. [K] told me that although this had been offered to her previously, she had not taken this up for she was still in denial about her blindness. As already stated [K] is still in the process of adjusting to and coming to terms with this disability. She struggles with feelings of bitterness and anger about this. She is also conflicted about whether she is cursed and has somehow caused this to happen.
- 22.2 This conflict and confusion is likely to increase if she is returned to Kenya where she may be perceived to be cursed on face rejection by her family. Increased feelings of shame and stigma due to her disability are likely to be a barrier to help her accessing help.

- 22.3 [K] already has difficulty asking for help from other people and she does not like being dependent on other people for fear of being a burden to them or of being let down and hurt. Over time she has become more able to trust her partner and her mother and to accept their help and support. However, although she feels that they accept and love her, she still finds this difficult. She has established good relationships with the network of professionals involved in her care over the years.
- 22.4 In my view, she will find it very difficult accessing services with people who are completely unknown to her and with whom she has no previous history. As already stated her depression and anxiety symptoms are likely to increase if returned. These symptoms will also have an impact on her motivation and capacity to initiate steps and seek services and acquire the help she would require.
- 22.5 In addition, her tiredness consequent to her illness and treatment coupled with a lack of sleep will interfere with her capacity to take care of her needs and access services. Her visual impairment will be another major barrier to her being able to seek help. [K] feels afraid and insecure in any new environment and she is unlikely to manage finding her way to new places and services unsupported. She told me that she does not know where she would live, how she would start building a life for herself and who she would turn to.
- 22.6 [K] told me that she does not trust the authorities in Kenya to help her. She said that they failed her mother before she does not trust that they will be able to keep a safe as she is from a minority group.
- 26.7 I am unable to comment on what conditions [K] would face on return. However, I am of the opinion that her mental health problems will have a detrimental impact on her ability to secure her needs and to access the medical and psychological care she requires. Given her current vulnerability and mental health needs, I do not believe [K] will be able to take the necessary steps to provide for her basic needs and to access necessary services. In my view, this would render her vulnerable and at risk of abuse and an associated deterioration in her mental state.

23. Please comment on [K] personal coping mechanisms

- 23.1 [K] attends church regularly and her faith is an important source of comfort and support to her.
- 23.2 One of her key coping strategies is to keep herself busy and following a well structured routine of daily activities. This appears to be strategy she has used from a young age. [K] has a very structured week which includes voluntary work in a charity shop and a community organisation. She also has scheduled times with her mother and her partner. [K] also has regular contact with friends and her cancer network.
- 23.3 [K] acknowledged that she tries hard to keep herself as busy as she can as this helps to distract her from her worries. In my opinion, if she did not have this structure and distraction, she would be overwhelmed by her anxiety and her depression would be exasperated.
- 23.4 [K] also seeks reassurance from her cancer team as when and needed as a way of managing her health anxieties.
- 23.5 Although [K] does seek support and reassurance from her mother and partner this makes a significant contribution to her coping, this is not always easy for her. Her fear of dependents and of being hurt or let down can be a barrier to her accessing this support when she is feeling vulnerable.

- 23.6 When [K] usual coping strategies fail, she tends to “zone” out or disassociate. Disassociation is a lack of the normal integration of thoughts, feelings, and experiences into the stream of consciousness and memory. It is a reaction both to traumatic events as well as high levels of stress. Disassociation can be thought of as both a neurological response to threat and psychological defence to protect from an overwhelming experience. Disassociation places people at risk as they are less aware of their surroundings and [K] told me that on one occasion she was nearly hit by a car when she was in this state. The psychiatric nurse has been teaching her ways of grounding herself which she is able to use. I would be concerned if her tendency to disassociate increased in the face of increased stress and would recommend that this needs close monitoring.