Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: PA/00682/2019**

THE IMMIGRATION ACTS

Heard at Field House	**Decision and Reasons**
On 29 March 2022	**Promulgated**
	On the 13th September 2022

Before

UPPER TRIBUNAL JUDGE CANAVAN
DEPUTY UPPER TRIBUNAL JUDGE STOUT

Between

A R
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Anonymity
Pursuant to rule 14 of The Tribunal Procedure (Upper Tribunal) Rules 2008, the appellant is granted anonymity. No-one shall publish or reveal any information, including the name or address of the appellant, likely to lead members of the public to identify the appellant. Failure to comply with this order could amount to a contempt of court.

Representation:
For the appellant: Mr J. Martin, instructed by Indra Sebastian Solicitors
For the respondent: Miss Lecointe, Senior Home Office Presenting Officer

DECISION AND REASONS

1. The appellant appealed the respondent's decision dated 19 November 2018 to refuse a protection and human rights claim.

2. There has been a long procedural history to this appeal, but it is only necessary to set out recent events. First-tier Tribunal Judge Wylie dismissed the appeal on protection and human rights grounds in a decision promulgated on 30 June 2021. The appellant did not seek to challenge her findings relating to the protection aspect of the claim but was granted permission to appeal to the Upper Tribunal in respect of the findings relating to Articles 3 and 8 of the European Convention on Human Rights. The Upper Tribunal set aside that part of the First-tier Tribunal decision in an error of law decision promulgated on 13 January 2022 (annexed).

3. The human rights aspect of the appeal was relisted for the Upper Tribunal to remake the decision. The appellant is said to be particularly unwell and is described in parts of the evidence as being wholly reliant on his family members in the UK. He was assessed by a consultant psychiatrist to lack capacity to understand a court hearing. Despite this, he attended the hearing unaccompanied by any family members. In light of the evidence from Dr Robin E. Lawrence he was not called to give evidence.

4. The issues are narrowed for the purpose of remaking. The Upper Tribunal is asked to determine whether there is a real risk that the appellant's removal to Sri Lanka would breach Article 3 on suicide risk/mental health grounds or would breach Article 8.

5. The submissions made by the parties are a matter of record. We will refer to the relevant evidence and submissions when we make our findings.

Legal framework

6. Claims involving medical issues and suicide risk are particularly difficult to decide. A case brought on human rights grounds based on a person's medical condition is one that comes within the '*N* paradigm': see *N v SSHD* [2005] UKHL 31; [2005] 2 AC 296 and *N v United Kingdom* 26565/05 [2008] ECHR 453 (27 May 2008); (2008) 47 EHRR 39. In such cases the threshold for showing a breach of human rights is particularly high. The European Convention on Human Rights does not place an obligation on a host state to refrain from removal where the feared harm does not emanate from intentionally inflicted acts of the public authorities in the receiving state, but instead from a naturally occurring illness.

7. The European Court of Human Rights found that it was only in the most exceptional circumstances of the kind faced by the applicant in the case of *D v UK* (1997) 24 EHRR, who was in the final stages of a terminal illness facing a distressing death without family or other support in the receiving state, that compelling humanitarian considerations were found to engage the operation of Article 3.

8. The extent to which there might be 'other very exceptional cases' beyond those of the deathbed scenario identified in *D* has been the subject of ongoing consideration by the courts. Following a period of flux, a series of decisions have clarified the approach in such cases. Those decisions include *Paposhvili v Belgium* [2017] Imm AR 867, *AXB v SSHD* [2019] UKUT 397 (IAC), *AM (Zimbabwe) v SSHD* [2020] UKSC 17; [2021] AC 633, and *Savran v Denmark* [2021] ECHR 1025. This culminated in a recent distillation of the test by the Upper Tribunal in *AM (Art 3; health cases) Zimbabwe* [2022] UKUT 00131 (IAC).

9. The Upper Tribunal found that the initial threshold test involves two questions:

   (1) Has the person discharged the burden of establishing that he or she is 'a seriously ill person'?

   (2) Has the person adduced evidence 'capable of demonstrating' that 'substantial grounds have been shown for believing' that as 'a seriously ill person', he or she 'would face a real risk':

      (i) 'on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment,

      (ii) of being exposed to:

         (a) a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering, or

         (b) a significant reduction in life expectancy?

10. The first question will generally require clear and cogent medical evidence from treating physicians in the UK. In *HA (expert evidence; mental health) Sri Lanka* [2022] UKUT 00111 the Upper Tribunal recently gave the following guidance on the preparation of psychiatric and psychological reports in immigration cases:

> '(1) Where an expert report concerns the mental health of an individual, the Tribunal will be particularly reliant upon the author fully complying with their obligations as an expert, as well as upon their adherence to the standards and principles of the expert's professional regulator. When doctors are acting as witnesses in legal proceedings they should adhere to the relevant GMC Guidance.
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> (2) Although the duties of an expert giving evidence about an individual's mental health will be the same as those of an expert giving evidence about any other matter, the former must at all times be aware of the particular position they hold, in giving evidence about a condition which cannot be seen by the naked eye, X-rayed, scanned or measured in a test tube; and which therefore relies particularly heavily on the individual clinician's opinion.
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> (3) It is trite that a psychiatrist possesses expertise that a general practitioner may not have. A psychiatrist may well be in a position to diagnose a variety of mental illnesses, including PTSD,

following face-to-face consultation with the individual concerned. In the case of human rights and protection appeals, however, it would be naïve to discount the possibility that an individual facing removal from the United Kingdom might wish to fabricate or exaggerate symptoms of mental illness, in order to defeat the respondent's attempts at removal. A meeting between a psychiatrist, who is to be an expert witness, and the individual who is appealing an adverse decision of the respondent in the immigration field will necessarily be directly concerned with the individual's attempt to remain in the United Kingdom on human rights grounds.

(4) Notwithstanding their limitations, the GP records concerning the individual detail a specific record of presentation and may paint a broader picture of his or her mental health than is available to the expert psychiatrist, particularly where the individual and the GP (and any associated health care professionals) have interacted over a significant period of time, during some of which the individual may not have perceived themselves as being at risk of removal.

(5) Accordingly, as a general matter, GP records are likely to be regarded by the Tribunal as directly relevant to the assessment of the individual's mental health and should be engaged with by the expert in their report. Where the expert's opinion differs from (or might appear, to a layperson, to differ from) the GP records, the expert will be expected to say so in the report, as part of their obligations as an expert witness. The Tribunal is unlikely to be satisfied by a report which merely attempts to brush aside the GP records.

(6) In all cases in which expert evidence is adduced, the Tribunal should be scrupulous in ensuring that the expert has not merely recited their obligations, at the beginning or end of their report, but has actually complied with them in substance. Where there has been significant non-compliance, the Tribunal should say so in terms, in its decision. Furthermore, those giving expert evidence should be aware that the Tribunal is likely to pursue the matter with the relevant regulatory body, in the absence of a satisfactory explanation for the failure.

(7) Leaving aside the possibility of the parties jointly instructing an expert witness, the filing of an expert report by the appellant in good time before a hearing means that the Secretary of State will be expected to decide, in each case, whether the contents of the report are agreed. This will require the respondent to examine the report in detail, making any investigation that she may think necessary concerning the author of the report, such as by interrogating the GMC's website for matters pertaining to registration.

11. The second question is multi-layered and will depend on the facts of each case. It is insufficient for a person to show that their condition would worsen upon removal. They must show that there will be 'intense suffering'. Medical experts based in the UK may be able to assist in this assessment, but many cases are likely to turn on the availability of and

access to treatment in the receiving state. Such evidence is more likely to be found in reports by reputable organisations, clinicians, and country experts with contemporary knowledge or expertise in medical treatment and country conditions in the receiving state. It is only after the threshold test has been met and Article 3 is engaged that the returning state's obligations, outlined in *Savran* ([130]and [135]) might become relevant.

12. We note that the Upper Tribunal in *AXB v SSHD* [2019] UKUT 397 (IAC) conducted a detailed analysis of the case law before concluding that the *N* threshold applies in cases involving suicide risk [96]-[104]. However, we consider that a simpler route is found in the lead decisions relating to suicide risk, which show that the *N* threshold has always formed part of the assessment.

13. The Court of Appeal decisions in *J v SSHD* [2005] EWCA Civ 629 and *Y (Sri Lanka) v SSHD* [2009] EWCA Civ 362 govern a discrete area of assessment under Article 3 relating to suicide risk. The decisions in *J* and *N* were heard at around the same time in May 2005. By the time the Court of Appeal in *J* handed down its decision, it had the benefit of the House of Lords decision in *N*. The Court of Appeal conducted a detailed review of the European and domestic case law. The six points it drew from these authorities for the purpose of assessing Article 3 in the context of suicide risk were:

> '26. First, the test requires an assessment to be made of the severity of the treatment which it is said that the applicant would suffer if removed. This must attain a minimum level of severity. The court has said on a number of occasions that the assessment of its severity depends on all the circumstances of the case. But the ill-treatment must "necessarily be serious" such that it is "an affront to fundamental humanitarian principles to remove an individual to a country where he is at risk of serious ill-treatment": see *Ullah* paras [38-39].
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> 27. Secondly, a causal link must be shown to exist between the act or threatened act of removal or expulsion and the inhuman treatment relied on as violating the applicant's article 3 rights. Thus in *Soering* at para [91], the court said:
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> > "In so far as any liability under the Convention is or may be incurred, it is liability incurred by the extraditing Contracting State by reason of its having taken action which *has as a direct consequence the exposure of an individual to proscribed ill-treatment.*"(emphasis added).
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> See also para [108] of *Vilvarajah* where the court said that the examination of the article 3 issue "must focus on the foreseeable consequences of the removal of the applicants to Sri Lanka…"
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> 28. Thirdly, in the context of a foreign case, the article 3 threshold is particularly high simply because it is a foreign case. And it is even higher where the alleged inhuman treatment is not the direct or indirect responsibility of the public authorities of the receiving state, but results from some naturally occurring illness, whether physical or mental. This is made clear in para [49] of *D* and para [40] of *Bensaid.*

> 29. Fourthly, an article 3 claim can in principle succeed in a suicide case (para [37] of *Bensaid*).
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> 30. Fifthly, in deciding whether there is a real risk of a breach of article 3 in a suicide case, a question of importance is whether the applicant's fear of ill-treatment in the receiving state upon which the risk of suicide is said to be based is objectively well-founded. If the fear is not well-founded, that will tend to weigh against there being a real risk that the removal will be in breach of article 3.
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> 31. Sixthly, a further question of considerable relevance is whether the removing and/or the receiving state has effective mechanisms to reduce the risk of suicide. If there are effective mechanisms, that too will weigh heavily against an applicant's claim that removal will violate his or her article 3 rights.'

14. The first three points set out the basic requirements to show a breach of Article 3. The third point made clear that there is an enhanced threshold in cases that come within the *N* paradigm. The last three points went beyond the decision in *N* to consider the context in cases involving the assessment of suicide risk. The Court of Appeal in the *Y (Sri Lanka)* modified the fifth point as follows:

> '15. … The corollary of the final sentence of §30 of *J* is that in the absence of an objective foundation for the fear some independent basis for it must be established if weight is to be given to it. Such an independent basis may lie in trauma inflicted in the past on the appellant in (or, as here, by) the receiving state: someone who has been tortured and raped by his or her captors may be terrified of returning to the place where it happened, especially if the same authorities are in charge, notwithstanding that the objective risk of recurrence has gone.
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> 16. One can accordingly add to the fifth principle in *J* that what may nevertheless be of equal importance is whether any genuine fear which the appellant may establish, albeit without an objective foundation, is such as to create a risk of suicide if there is an enforced return.'

15. The assessment of suicide risk is a discrete aspect of the extension to Article 3 considered in *D* and *N*. In *MM (Malawi) v SSHD* [2018] EWCA Civ 2482 counsel for the Secretary of State accepted that it was a distinct area of assessment under Article 3 [63]. The Court of Appeal in *J* made clear that there was a high threshold in 'foreign cases', and acknowledging the decisions in *D* and *N*, made clear that the threshold was even higher in cases where 'the alleged inhuman treatment is not the direct or indirect responsibility of the public authorities of the receiving state'.

16. The nature of the potential harm in a suicide risk case is sufficiently serious to engage the operation of Article 3 within the meaning of the *N* paradigm. If a person can show that there is a real risk that they will commit suicide on return to the receiving state, the feared harm clearly

meets the minimum level of severity required i.e. intense mental suffering leading to their imminent death.

17. The fifth and sixth points highlighted in *J,* modified in *Y (Sri Lanka)*, simply focus the assessment on issues specific to the circumstances relating to suicide risk. First, an initial assessment of whether there is a real risk that the person is likely to commit suicide if returned to the receiving state. This would normally be assessed with reference to expert psychiatric evidence. Second, whether effective measures can be put in place before, during and after removal to reduce the risk of suicide below a real risk. This would normally be assessed with reference to evidence relating to the circumstances in the receiving state. In this way the existing guidance relating to the assessment of cases involving suicide risk already covered the questions recently identified by the Upper Tribunal in *AM (Zimbabwe)* (2022).

Decision and reasons

18. We will summarise the relevant facts and evidence before considering whether the appellant's circumstances engage the legal framework relating to medical/suicide risk cases.

19. The appellant is a Sri Lankan citizen of Sinhalese ethnicity. It is not disputed that he continues to have close family ties in Sri Lanka including his wife, two children, and his parents. The evidence indicates that at the date of the hearing the appellant's son is 20 years old and his daughter is 15 years old. The appellant is an educated person who obtained Masters degrees in Sri Lanka and the UK. In the past, the appellant has worked as a translator for the Sri Lankan government (English/Sinhalese) and for a biscuit manufacturing company (his qualifications include a Masters in Food Science & Technology).

20. The appellant entered the UK on 29 September 2008 with entry clearance as a student that was valid until 31 May 2010. His leave was extended until 26 December 2011. A subsequent application to extend leave to remain was refused. The appellant remained in the UK without leave until he was granted further leave to remain as a Tier 1 (Post-Study) Worker on 22 August 2012. The visa was valid until 24 August 2014. A subsequent application to extend leave to remain was refused and attempts to challenge the decision were unsuccessful. The appellant then made a series of unsuccessful applications to remain in the UK on a variety of grounds including making a human rights claim and an application under EU law. It was not until May 2018, when he was detained with a view to removal, that he claimed asylum. At that point the appellant had remained in the UK without leave for nearly four years.

21. The appellant claimed that he would be at risk on return to Sri Lanka because of his perceived support for the LTTE. He said that his parents had

rented rooms to two Tamil men in 1995. He claimed that unknown people came to his house in 2007, some 12 years later, seeking to arrest him for supporting these men who were suspected of involvement in a terrorist attack that took place in 1995. The appellant claimed that he went into hiding for around 10 months before applying for a student visa to come to the UK. He left the country without difficulty. It is recorded that the appellant returned to Sri Lanka in November 2012 for three months. He also returned to Sri Lanka for a short visit in May 2013. The appellant has never been arrested or detained in Sri Lanka. However, he claimed that the authorities came to his home on a regular basis seeking to arrest him. He feared that he would be arrested, detained or killed by the authorities if he returned to Sri Lanka.

22. The appellant's asylum claim was refused. An initial appeal was dismissed by a judge of the First-tier Tribunal. The judge did not find the appellant's account credible and concluded that he did not have a well-founded fear of persecution. The decision was set aside by a judge of the Upper Tribunal and remitted to the First-tier Tribunal for a fresh hearing. First-tier Tribunal Judge Wylie also found that the appellant's account lacked credibility and concluded that he would not be at risk on return to Sri Lanka. The appellant did not seek to appeal these findings. We proceed in our assessment on the basis that the appellant has failed to show that he would be at risk on return to Sri Lanka from the authorities or any other person.

23. The appellant's claim now hinges solely on the effect that removal to Sri Lanka would have on his mental health. It is not disputed that the appellant is likely to suffer from some symptoms of depression and anxiety. The arguments at the hearing focussed on whether the evidence showed that his condition is so serious that removal would breach Articles 3 or 8 on medical/suicide risk grounds.

24. When the appellant was interviewed by the Home Office in relation to his asylum claim in 2018 he said that he did not have any medical conditions (the questions were directed to physical ailments) and was not taking any medication. In an initial asylum statement dated 25 July 2018 he said that he had tried to commit suicide in the UK once in 2010 because he was frightened to return to Sri Lanka (subsequently he returned for visits in 2012 and 2013) and because he was 'struggling to cope… living without my family.' He said that he was still 'mentally disturbed' and was waiting to be referred for counselling and for medication.

25. The respondent refused the protection claim in a decision date 19 November 2018. The decision considered whether removal would lead to a breach of Article 3 on medical/suicide risk grounds. It seems that the respondent's consideration was based solely on what was said in the appellant's initial statement. No medical or psychiatric reports seem to have been prepared at that early stage.

26. By the time Judge Moffat first heard the appeal on 08 November 2019 the appellant had been assessed privately by Dr Robin E. Lawrence, a consultant psychiatrist. There is no dispute that he is qualified to comment on the appellant's mental health. In all his reports he has made clear that he understands his role as an expert witness. The issue for us to assess is what weight can be placed on the conclusions he has reached in a series of reports given the circumstances in which he was asked to make his assessment and taking into account the fact that he is not the appellant's treating clinician.

Dr Lawrence's report (30/04/2019)

27. Dr Lawrence's first report is dated 30 April 2019. He proceeded on the assumption that the appellant's account should be believed although he made clear at the end of the report that he had considered whether it was possible that the appellant could be simulating his symptoms. Dr Lawrence was instructed by the appellant's solicitors. The only documents he was provided with related to the appellant's asylum claim. Dr Lawrence made clear that he had not seen the appellant's medical notes. He reported that he was told that the appellant had been having serious mental health issues and was waiting for his GP to arrange counselling sessions. It was reported to Dr Lawrence that the appellant was affected by mental health problems in or around 2009 or 2010 and was contacted by Brent Mental Health Team. What treatment he received, if any, is not recorded in the report.

28. The appellant attended the assessment with his niece's husband. The history recorded in the report includes information provided by the appellant and his relative. Dr Lawrence made observations about the appellant's presentation, noting significant psychomotor retardation (slowness of response). The report was inconsistent in stating at one point that the appellant appeared not orientated, and at another, that he was fully orientated. The appellant was described as having become particularly dependent on his niece's family in the last 2-3 years since he was released from detention. The appellant told Dr Lawrence that he had attempted suicide when he was at university and spoke to some people in Brent. When Dr Lawrence asked the appellant about suicide, he told him that 'he wants to kill himself all of the time'. He was able to give a description of how he might harm himself. His family in the UK appeared to be a protective factor.

29. Dr Lawrence concluded that the appellant was likely to be suffering from severe depression with psychotic features. He also noted symptoms of Post-traumatic Stress Disorder (PTSD) despite the fact that he was unable to identify anything in the appellant's history to indicate an index trauma. As a result, he concluded that it was possible that the appellant might have developed 'a delusional memory that is traumatizing him' causing a fear of forced return to Sri Lanka. Dr Lawrence noted that the appellant was said to be prescribed with anti-depressant medication. In the absence of any medical notes, he speculated that the appellant 'is probably being

treated by the local mental health team.' He recommended that the appellant might benefit from anti-psychotic medication.

30. Dr Lawrence assessed the appellant to be suffering from a 'severe and enduring mental illness'. In relation to suicide risk, in view of his diagnosis of psychotic depression, he considered it 'very, very likely that he would attempt and successfully complete his suicidal urge' if returned to Sri Lanka. He went on to say: 'It is possible that his wife would be able to support him and protect him from these urges but this is not necessarily so particularly as his children may be young.' Although he recognised that the appellant's family in Sri Lanka might be a protective feature, he considered that his fear of return, whether real or imagined, was so strong that it 'would overwhelm these protective features.'

Medical records (2009-2019)

31. An unindexed bundle on the court file contains a copy of the appellant's GP records, which state that they were printed on 19 July 2019. The GP records contain a note of his initial registration in 2009 but largely relate to a period from June 2017 to July 2019. The bundle also includes various pieces of medical correspondence from 2018. The documents were before Judge Moffat when she heard the initial appeal. She noted inconsistencies in the picture presented to Dr Lawrence about the appellant's symptoms and level of suicidal ideation compared with the information noted in the GP records.

32. A bundle of documents was filed and served by the appellant's solicitors by cover letter 18 July 2019 for a hearing initially listed on 24 July 2019. It is reasonable to infer from the date that the GP records were printed out that the unindexed bundle was likely to have been handed up at that hearing. The judge's note of the hearing indicates that 'GP notes & records' were among the documents checked during the hearing. The judge's note also suggest that a discussion might have taken place about the possibility of providing the medical records to Dr Lawrence. The note states: 'Send to Dr Lawrence. With or without supp report from Dr Lawrence matter will proceed'. The hearing was adjourned because the appellant's niece could not attend as a witness. It was relisted on 08 November 2019.

33. A letter from the Central and North West London NHS dated 13 August 2018 confirmed that the appellant had been referred to the local mental health team. A form dated 21 August 2018 gives the outcome of the triage that followed. The form records that the appellant presented with depression, low mood, 'thoughts of not being here' and anxiety for a few months. The appellant reported feeling better since talking with his niece and seeing his GP. He described poor sleep and 'distressing "illusions" when he is awake at night'. He described being in a low mood 'for some time' and a history of depression since 2010. The triage form reports that his sleep had improved since taking anti-depressant medication and 'he has no current thoughts of not being here'. He had counselling in the past

and agreed to be referred for talking therapy. The clinical practitioner who assessed the appellant recorded his form of thought as 'Logical/Coherent' and speed 'appeared normal'. The appellant was assessed to have 'no delusions, abnormal beliefs' or paranoia. The risk to self was recorded as 'low' with no current suicidal ideation and 'only ever passive fleeting suicidal ideation' in the past. No safeguarding concerns were identified. The initial impression was that he was suffering from 'low-moderate depression and anxiety'.

34. The other correspondence in the bundle relates to investigations into a complaint of chest pain in 2018. The only aspect to note is a letter from the hospital to his GP dated 13 December 2018 reporting a history of 'longstanding depression'.

35. The GP records only provide a snapshot of the appellant's medical history during a two-year period leading up to the date they were printed. His initial registration at a GP surgery is recorded on 08 June 2009. There is no record of a mental health crisis or referral to mental health services in 2010. The notes show a series of records during June and July 2017 noting general health information. There is no indication that the appellant talked to his doctor about mental health issues at that time. The first note that records mental health issues is dated 02 August 2018. Given that the appellant was detained in May 2018 this would appear to be after his release. The evidence from the appellant's relatives in the UK indicates that he found detention particularly difficult. It seems that this might have contributed to some of his mental health problems.

36. On 02 August 2018 the GP recorded the following history. The appellant told his doctor that he felt depressed when he was at university about eight years before. He had counselling, which helped. He did not take anti-depressants at the time. The notes record: 'Similar thoughts of not being here but no attempt of suicide.' On further questioning he had not made any active plans to harm himself. He said that he 'feels frustrated when thinking about his situation' due to 'personal issues' that he did not want to discuss. The GP conducted a PHQ9 assessment (Patient Health Questionnaire relating to mental health). The result is recorded as 'Generalised anxiety disorder 7 item score 17/21'. The appellant was prescribed an anti-depressant medication and referred to the local CMHT for counselling. Other entries in August 2018 repeatedly record that the appellant denied any suicidal thoughts. His mood was recorded to be a bit better with the medication and he was due to start counselling on 24 August 2018.

37. On 18 September 2018 the appellant had a follow up visit to the GP after he had been assessed by the local mental health team (see [33] above). He said that his mood and sleep were slightly better, but he still woke up occasionally during the night. As noted in the triage report, the appellant reported seeing colours and shapes. The GP note states that he denied hearing any voices and did not have hallucinations.

38. The appellant had another appointment with his GP on 15 November 2018. He was awaiting an appointment for talking therapy. The notes record no suicidal thoughts, no nightmares/hallucinations. He was observed to have a flat effect but good eye contact with normal speech. Further follow up visits to the GP into 2019 repeatedly recorded that the appellant denied any suicidal thoughts, had good eye contact, and normal speech.

39. By 24 January 2019 the notes state that the appellant had missed counselling contact on two occasions. The GP agreed to re-refer him for counselling. On 12 March 2019 the notes continued to record that the appellant suffered from generalised anxiety disorder, denied suicidal thoughts, denied any dreams/hallucinations but 'thinks about his family back in Sri Lanka'.

40. By 26 March 2019 the notes suggest that the appellant was inactive in response to contact from the local mental health team. The notes stated that he was 'aware may be removed from waiting list again if does not contact them.' By 16 May 2019 the notes recorded that the doctor discussed talking therapies again with him but he 'declines for now.' The same record also states: 'Since running out of medications poor sleep and thinking about family in Sri Lanka: worries about them.'

41. A further review on 11 June 2019, at a time when his asylum appeal was now likely to be in progress, noted that he should be re-referred to the mental health team because his PHQ9 score was quite high. The doctor observed: '?slowness due to depression ?alt cause'. The appellant continued to deny any suicidal thoughts. The note states: 'Still thinks about family in Sri Lanka and also his own future in this country – not working, still living with his niece.' Aside from the GP noting what the appellant said about counselling in 2010, there is no evidence to show that the appellant attended counselling in the period from 2017-2019, despite referrals, or at any time in the period since then.

Dr Lawrence's report (10/05/21)

42. Judge Moffat's decision was set aside by the Upper Tribunal in a decision sent on 28 January 2021. Dr Lawrence was asked to provide an updated assessment of the appellant's mental health. The report dated 10 May 2021 was prepared for the fresh hearing before Judge Wylie on 04 June 2021.

43. When this appeal was first adjourned in July 2019, the judge's note on the court file indicates that it was suggested that Dr Lawrence should be provided with the GP records in preparation for the hearing that eventually took place on 08 November 2019. That was not done. Despite Judge Moffat's comments about the contrast between the picture presented to Dr Lawrence and the GP records, Dr Lawrence was still not provided with

any medical records relating to the appellant's ongoing presentation and treatment when he prepared his second report just over two years later.

44. The second report made no further comment on suicide risk. Judge Wylie noted that, in contrast to the information he had given Dr Lawrence during the first assessment, when he said that the appellant had been unwell for the last two years, the appellant's relative claimed that he had 'always been like this'. Dr Lawrence considered that there had been a significant deterioration in the appellant's mental health. He did not appear orientated in time and place. He did not understand why he was at the consultation and continued to be clinically depressed. Dr Lawrence considered that the appellant would be unable to look after himself if he returned to Sri Lanka. In Dr Lawrence's opinion the appellant would never recover from his condition even if the psychosis receded.

GP letter (03/03/22)

45. Although many of her findings were open to her to make, Judge Wylie's decision was set aside by the Upper Tribunal due to small but material omissions in her findings relating to the medical/suicide risk aspect of the claim.

46. In preparation for the renewed hearing before the Upper Tribunal on 20 March 2022, the appellant's representatives wrote to his GP to ask for an update on his condition. No request was made for copies of the GP records. The response was a one-page letter from his GP giving a very generalised summary of his medical history. No further up to date information was provided beyond stating that he continued to be reviewed by his GP and that his medication is reviewed by a psychiatrist.

Dr Lawrence's Report (13/03/22)

47. Dr Lawrence was asked to provide an update for the hearing. Again, he was provided with copies of documents relating to the appellant's asylum case, but no copy of his medical records. We note that some of the questions asked to Dr Lawrence were inappropriate. He was asked to comment on matters that were outside the proper area of his expertise. For example, he was asked to comment on what assistance the appellant would be able to access in Sri Lanka and whether he would be able to integrate.

48. In the third report, Dr Lawrence summarised his previous conclusions. Again, the appellant attended the consultation with his niece's husband. Dr Lawrence recorded the information given to him by the appellant's relative about the assistance that the he requires, which included helping him to make drinks and reminding him to bathe. Dr Lawrence was told that the appellant gets lost 'so his family have to accompany him all the time.' His relative told Dr Lawrence that there had been 'a gradual deterioration since 2015'. Dr Lawrence records that his niece's husband speculated that

the appellant's health had deteriorated 'because of frustration and worries about Sri Lanka'.

49. Almost all the history taken by Dr Lawrence on this occasion seems to have come from the appellant's relative. A brief section records what the appellant told him. The appellant told Dr Lawrence that he can't concentrate. It was like his mind switched on and off. He always felt sad. The appellant told Dr Lawrence that his past was not good. He said that 'a lot of people in Sri Lanka were trying to kill him.' When asked why, he did not know. Although the summary does not indicate that the appellant told Dr Lawrence that he heard voices, Dr Lawrence asked him about 'the voices'. The appellant told Dr Lawrence that 'he heard a rushing noise.' He did not like the TV because it was noisy. He just wanders around the house and sits all the time.

50. Dr Lawrence's third report states that he stood by his earlier diagnosis. The appellant had symptoms of depression and paranoia. His depression was of a psychotic intensity. He also had some symptoms of PTSD or generalised anxiety. It is not clear which is diagnosed, but the latter is more consistent with the GP records. Dr Lawrence reiterated that the appellant needed anti-psychotic medication in addition to the anti-depressant medication he was already receiving. The report appears to contain a typographical error. Although Dr Lawrence refers to him needing 'an anti-depressant' in fact the medications he recommends are both anti-psychotic medications (Olanzapine or Trifluoperazine). This was consistent with his previous recommendation in 2019.

51. Dr Lawrence turned to answer some of the questions posed by the appellant's legal representative. He considered that removal would 'severely damage' the appellant's mental health. He was totally reliant on his niece and would be completely incapable of taking care of himself. Dr Lawrence went on to make the following statement: '[The appellant] would need 24 hour care wherever he lives and he would be unable to obtain this in Sri Lanka.' No further explanation is given. His finding is surprising given that he knew the appellant has close family members in Sri Lanka when he wrote his first report. Dr Lawrence failed to take this into account before concluding that care would not be available in Sri Lanka.

52. In response to the question about the current level of suicide risk, Dr Lawrence said:

> 'I asked him particularly about this and he said if he had to, he would hang himself. The fantasy of a violent form of suicide is associated with a much higher risk of successful suicide. It must be said that he also told me that he could think of taking an overdose. This of course has a much lower risk of actual suicide. I think he would try to kill himself were he to be detained and forcefully returned to Sri Lanka. I don't think he would find it possible in his current metal (sic) state to summon up the intention for a long period to successfully complete his plan.
>
> Sri Lanka has high levels of successful suicides because of the easy availability of poisonous Agro-chemicals – this also increases his risk.

> Nevertheless it is my expert opinion that death from neglect is the likeliest outcome were he to be living in Sri Lanka.
>
> …
>
> There is a far greater risk of death from self-neglect than successful suicide, I don't think it is possible to mitigate against that risk in any meaningful way, neither do I think it would be safe to put him on an airplane. He could have a panic attack and could behave in an unpredictable, even agressive (sic) way endangering himself and other passengers.
>
> …
>
> This man has a severe enduring mental illness. His prognosis is grim, he is totally dependent on his niece and her husband for all his daily needs and he will remain like this for the rest of his life. There is some possibility that with the removal of threat of returning to Sri Lanka together with a judicious use of anti-psychotic and anti-depressant medication that there could be some improvement to his mental state, but his prognosis has to be guarded.'

Dr Lawrence's Report (06/07/22)

53. At the end of the hearing we reserved our decision to reflect on the evidence. While preparing the decision, the President of the Upper Tribunal published a reported decision in the case of *HA (Sri Lanka)* (above). We considered that the parties needed an opportunity to address the issues raised in *HA (Sri Lanka)*. The Upper Tribunal issued directions highlighting the decision and noting that Dr Lawrence had at no point been provided with copies of the appellant's medical records. The parties were invited to make written submissions on the impact of *HA (Sri Lanka)* on this case, including any further applications deemed necessary, within seven days of the date the directions were sent in June 2022.

54. The appellant's legal representatives, Indra Sebastian Solicitors, have represented him throughout the appeal process. In a letter dated 08 July 2022 they filed and served a further report from Dr Lawrence dated 06 July 2022. The cover letter went on to state:

> 'Our client says, there have been issues getting the full medical history and a further updated report will be filed ASAP (when it comes to hand). This is in the best interests of the client.'

55. Dr Lawrence's fourth report served to create even less clarity. The report was not based on a further consultation. Dr Lawrence said that he gave his further opinion 'based upon the medical records which have been supplied to me by Indra Sebastian Solicitors.' Although he did not identify the document more clearly, we find that it is reasonable to infer that the 'notes' he was referring to was likely to be the GP letter dated 03 March 2022. This was the only document he was given. The content he described is also consistent with the letter.

> 'This information does not amount to a full medical history, although it does confirm that [the appellant] had depression in 2010 and August 2018 and

> that he was seen by a community Psychiatrist in 2018 and that he was diagnosed with moderate anxiety and depression.'

56. Dr Lawrence confirmed that he had read the decision in *HA (Sri Lanka)* and said: 'I have carefully considered the evidence given by both Dr Persaud and Professor Greenberg.'

57. Unfortunately, Dr Lawrence's opinion in the rest of the fourth report is based on a fundamental misunderstanding about the decision in *HA (Sri Lanka)*. Dr Lawrence wrongly believed that the opinion given by Professor Greenberg in that case related to this appellant, as can be seen from the following passage in his report:

> 'As can be easily seen from my previous reports, Professor Greenberg and I do not agree. Whenever previously, I have been in this position, the Court has directed that the two experts should confer and then reach the joint Conclusion. This has not been the direction in this particular case, but the direction that was made was that I should see the entirety of [the appellant's] notes, which has not been possible. In fact, I have no more information today, than I had the last time I wrote an Addendum, although I have had the opportunity to read the Judicial Directions and the Decision and Reasons of the Hearing on the 3rd and 4th March, Promulgated on the 25th March 2022.
>
> Impression and Conclusions
>
> It is very troubling that Professor Greenberg and I have come to essentially opposite conclusions when assessing the same patient. So long as I do not have access to [the appellant's] complete medical records, I am clearly at a significant disadvantage. I obviously have no idea if the Solicitors have resent the same material (cis a vis the medical records) with a covering letter saying that they have included all the medical records.
>
> We will contact them in case there are full medical records which have failed to be attached to their email to me.
>
> Despite Professor Greenberg's opinion, without any further evidence, I remain persuaded by those things which I have previously seen, heard and recorded in my previous report and Addendums.'

58. It is not necessary to summarise what is said in the rest of the report because it is based on the same mistaken assumption that the decision in *HA (Sri Lanka)*, and the opinion expressed by Professor Greenberg in that case, related to this appellant.

Conclusions

59. We are conscious of the delay in preparing this decision. Due to pressure of work the judge drafting the decision did not appreciate that further directions relating to *HA (Sri Lanka)* might be required until some weeks after the hearing. Although the directions created further delay, we considered that it was necessary for the parties to be given a fair opportunity to respond to the guidance given in *HA (Sri Lanka)*. Dr Lawrence's opinion is central to the appellant's case, but at no point has

he been provided with copies of the appellant's medical records to assist him in his assessment and diagnosis.

60. It is astounding that those representing the appellant did not check Dr Lawrence's final report before it was sent to the Upper Tribunal on 08 July 2022. The mistaken assumption he made about the case of *HA (Sri Lanka)* would have been apparent to any competent legal representative and should have been drawn to his attention. The accompanying correspondence suggested that further evidence might be forthcoming. Having waited a few weeks to see if anything more would be filed, we decided that the decision must be finalised. It is not a proportionate use of court time to make further directions when the appellant is legally represented. Nor is it in accordance with the overriding objective to delay the decision any further.

61. The evidence shows that the appellant is likely to be suffering from symptoms of depression and anxiety. We treat him as a vulnerable witness and have had regard to the relevant guidance. Our task is to evaluate the evidence to assess whether his condition is sufficiently severe as to engage the operation of Articles 3 and 8 of the European Convention.

62. We have set out the medical evidence in some detail so that anyone reading this decision can understand the full context. The appellant has been represented throughout by Indra Sebastian Solicitors. In 2019, the appellant and his solicitors were able to obtain a printout of his GP records, as well as other evidence from his treating clinicians, covering a period from 2017 to 2019. The evidence shows that the appellant has remained with the same GP throughout the duration of this appeal.

63. From an early stage the First-tier Tribunal suggested that Dr Lawrence should be provided with the appellant's medical records. The GP records were filed with the First-tier Tribunal as long ago as July 2019. Even though those records were available, at no point has Dr Lawrence been provided with a copy. No adequate reasons have been given to explain why up to date records covering the period from July 2019 onwards were not made available to Dr Lawrence or to the Upper Tribunal for the purpose of this appeal. As a result, much of the evidence is dated.

64. Having considered the evidence before us in detail we come to many of the same conclusions as the First-tier Tribunal judges who considered this appeal. Some of the difficulties with the medical evidence have only been compounded by the response to the directions made by the Upper Tribunal. There are inconsistencies and material omissions in the evidence that have not been adequately explained despite the observations made by two First-tier Tribunal judges.

65. There are notable differences in the overall picture outlined in the GP records and the information given to Dr Lawrence by the appellant and his relative.

(i) The GP records during 2018 and 2019 repeatedly record that the appellant denied any suicidal ideation. This contrasts markedly with the appellant telling Dr Lawrence in April 2019 that he thought about suicide 'all the time'.

(ii) The GP records note some depressive symptoms such as a 'flat effect' but in general do not provide a picture of the same severity as the one presented to Dr Lawrence in April 2019. On 26 March 2019 the GP records noted that the appellant had good eye contact, normal speech, and denied any suicidal thoughts. On 09 April 2019 he was recorded to have a 'flat effect', normal speech, denied suicidal thoughts, and his eye contact was noted to have improved during the consultation. A similar picture was recorded during a consultation on 16 May 2019 when the GP noted that the appellant declined, once again, to attend talking therapy when offered. Neither Dr Lawrence nor the Upper Tribunal have been provided with up to date GP records to assess his clinical presentation in the last three years.

(iii) The GP records and the CMHT assessment note that the appellant reported some visual distortions, but nothing in those records suggest that he was thought to be suffering from psychotic symptoms. The GP notes repeatedly record that the appellant did not report hallucinations. Nothing in the brief GP letter dated 03 March 2022 suggests that the appellant's depressive condition has ever thought to involve psychotic features. Despite Dr Lawrence's recommendation that anti-psychotic medication might assist the appellant, there is no evidence to suggest that this was reported to his GP. There is no evidence to show that he has been prescribed anti-psychotic medication in the nearly three-year period since the recommendation was made. If the appellant was suffering from such a severe mental illness involving psychotic symptoms it would be surprising if the GP records did not reflect such a serious level of illness.

66. Overall, the picture outlined in the GP notes and CMHT assessment over a period in 2018-2019, and the GP letter dated 03 March 2022, are broadly consistent with the diagnosis of low-moderate depression with anxiety. However, in our assessment the picture presented by that evidence does not appear to be consistent with the kind of 'severe and enduring' mental illness with psychotic features with a high level of suicide risk as diagnosed by Dr Lawrence in his first report.

67. There are inconsistencies within and between Dr Lawrence's various reports. It has already been noted that there was some level of inconsistency within the first report as to whether the appellant was oriented in time and place or not when he attended the consultation with Dr Lawrence in 2019.

68. We also note that Dr Lawrence's assessment relating to suicide risk changed over the course of the reports. The later reports also failed to consider material factors. In the first report, the main reason for concluding that the appellant would be at high risk of suicide appeared to

be the psychotic features of his illness. However, psychotic illness never appears to have been diagnosed by those providing treatment to the appellant, including the local CMHT. The GP records indicate that the appellant was referred for talking therapies on more than one occasion but chose not to engage with treatment. His treatment has been confined to standard anti-depressant medication.

69. In his first report, Dr Lawrence considered the fact that the appellant's wife and children lived in Sri Lanka. He recognised that this might be a protective factor in relation to suicide risk. Despite this potential support he considered that the appellant would still be overwhelmed because of the severity of his illness. He also speculated that the appellant's wife might not be able to provide sufficient support if their children were young. In fact, the children are older than Dr Lawrence assumed.

70. By the time Dr Lawrence prepared his third report in March 2022, his conclusions relating to suicide risk were somewhat confused and unclear (see [52] above). He noted that one form of ideation mentioned by the appellant had a higher risk while the other had a lower risk. He considered that the appellant might attempt to harm himself if threatened with removal, but was unlikely to focus for long enough to complete an attempt. He went on to give an emphatic opinion that the appellant was less likely to die as a result of suicide but more likely to die of neglect. In our assessment, his overall view as to the level of suicide risk in March 2022 was unclear. In concluding that the appellant was more at risk of neglect, Dr Lawrence failed to take into account the fact that the appellant has close family members in Sri Lanka, including his wife and parents, who are likely to be able to provide him with support.

71. As a consultant psychiatrist, Dr Lawrence is well qualified to comment on the appellant's mental health. However, he is not the appellant's treating clinician. His assessments were based on information reported to him by the appellant and his relative. We have outlined various inconsistencies in the information provided to Dr Lawrence, either between different consultations, or with what was recorded in the GP records.

72. The appellant or his legal representatives could have obtained a printout of the GP records because one was obtained from the same GP practice in July 2019. Despite it being suggested that the records should be provided to Dr Lawrence, he was asked to prepare his second report in a vacuum. No adequate reasons have been given to explain why up to date records were not obtained for this appeal. No adequate reasons have been given to explain why Dr Lawrence was not provided with up to date GP records in March 2022 or when specific directions were made by the Upper Tribunal in June 2022.

73. We are left in the deeply unsatisfactory position of having a broader range of information than was provided to Dr Lawrence. Even then, the GP records for the last three years are missing. The appellant's case hinges heavily on Dr Lawrence's report, but for the reasons given above we are

unable to give the same weight as we might normally do to the opinion of a consultant psychiatrist. Dr Lawrence was left in the difficult position of assessing the appellant's mental health without the benefit of his medical records. We accept that a qualified consultant will administer a range of standardised assessments and will also use their clinical experience to make observations about the presentation of the person before them. Nevertheless, Dr Lawrence was heavily reliant on the information reported to him by the appellant and his relative.

74. It is not possible to know whether Dr Lawrence's opinion might be different if he had access to detailed GP records for the last 3-4 years. On the face of the dated information contained in those records, those treating the appellant, including the local CMHT, only diagnosed him as suffering from low-moderate depression with anxiety. This picture contrasts quite sharply with Dr Lawrence's conclusion that the appellant is suffering from a severe and enduring mental illness with psychotic features from which he is never likely to recover.

75. We also have a slightly broader picture than Dr Lawrence as to how reliant the appellant is likely to be on his family members in the UK for support. The picture that seems to have been presented to Dr Lawrence was one of nearly infantile dependence. The first hearing of this case was adjourned for the appellant's niece to give evidence, yet she did not appear at the subsequent or any other hearing as a witness. Nor did her husband. Despite the high level of claimed dependence, the appellant attended the hearing before the Upper Tribunal unaccompanied. The records suggest that he also attended the First-tier Tribunal hearing in November 2019. He also attended the second hearing held by video link from his solicitors' office. Again, there is no indication that he was accompanied by a relative.

76. We accept that the evidence shows that the appellant suffers from low-moderate depression and anxiety. The cause of his mental illness is unclear. The GP records suggest that he worries about his family in Sri Lanka and his longer-term position in the UK. The difficulties he had after he was released from immigration detention also indicate that his detention had a negative impact upon his mental health. The appellant's asylum claim has been considered and it has been concluded that there is insufficient evidence to show that he would be at risk if returned to Sri Lanka. There is no history of previous detention or ill-treatment in Sri Lanka. No past traumatic event has been identified that might underly the psychotic and paranoid features reported to Dr Lawrence.

77. As Dr Lawrence accepted, it is not his role to piece together the evidence relating to the credibility of the appellant's account. Quite rightly, he took the history given to him at its highest. He did so without the benefit of the appellant's medical records, which may have given him an insight into the appellant's presentation and treatment over a longer period. There is no evidence to show that those treating the appellant have diagnosed him with a serious and enduring illness with psychotic features. There is no evidence to show that he has been treated for psychotic illness despite Dr

Lawrence's recommendation. Whilst recognising that there is a stigma relating to mental illness in some communities that might act as a bar to engaging with mental health treatment, we find it surprising that the appellant would not engage with talking therapy if he was as severely unwell as Dr Lawrence suggests. The evidence indicates that the only treatment that the appellant is likely to be receiving is anti-depressant medication, which is reviewed on a regular basis.

78. We accept that the appellant has been struggling with depression and anxiety for some time and is clearly worried about his family in Sri Lanka. He is also worried about his long-term position in the United Kingdom. However, having reviewed all of the evidence as a whole, there is insufficient reliable evidence to show that his condition is such that there would be a real risk of self-harm or suicide if returned to Sri Lanka. We have set out why the opinions expressed by Dr Lawrence about the current level of suicide risk are somewhat confused and unclear and why we attributed limited weight to them. Dr Lawrence's opinion about self-neglect failed to take into account the fact that family support is available in Sri Lanka. This is likely to act as a protective factor as it has done in the UK.

79. No doubt the appellant is likely to be distressed and worried about returning to Sri Lanka having lived in the UK for 14 years. However, he is an educated person who has worked and supported himself in Sri Lanka in the past. Even if the appellant's depressive illness might make self-care difficult, he would have the support of close family members including his wife and now adult son. Despite the stated severity of his condition, he is only being treated by way of anti-depressant medication. The respondent's CPIN 'Sri Lanka: Medical treatment and healthcare' (Version 1.0) July 2020 at [8.9.2] states that Mirtazapine is available in Sri Lanka. Although the appellant's bundle contains generalised evidence relating to the economic crisis now unfolding in Sri Lanka, our attention was not drawn to anything in that evidence to show that the medication the appellant requires is no longer available.

80. For the reasons given above, we conclude that the evidence produced on behalf of the appellant is not sufficiently reliable to conclude that there are substantial grounds for believing that he is suffering from a serious mental illness of the kind that would engage the high threshold to engage Article 3.

81. The Article 8 claim is focussed on the same evidence and has an equally high threshold in such circumstances. It was argued that there would be very significant obstacles to integration because of the evidence relating to self-neglect. Paragraph 276ADE(1)(vi) of the immigration rules is primarily designed for those who may have few remaining connections with their country of origin and would genuinely find it difficult to reintegrate.

82. In this case, the appellant was born and grew up in Sri Lanka. He has spent most of his life there. He was educated and worked there. The appellant

came to the UK to study when he was 37 years old. He continues to have close family connections in Sri Lanka. There is sparse evidence about the strength of his connections to his niece and her husband who are said to care for him in the UK. We have already found that there is insufficient evidence before us to conclude that the high threshold for medical/suicide risk claims is engaged. The limited treatment currently given to the appellant for depression by way of medication is likely to be available in Sri Lanka. He would also have the support of close family members. For these reasons, we conclude that the appellant would be able to reintegrate in Sri Lanka within a reasonable period of time with the assistance and support of his family members. He does not meet the requirements of paragraph 276ADE(1)(vi) of the immigration rules.

83. The immigration rules are an indication of where the respondent considers a fair balance is struck between a person's right to private and family life and the public interest in maintaining an effective system of immigration control. The appellant does not meet the requirements of the immigration rules and has remained in the UK without leave since 2014. There is little evidence of any significant connections forged in the UK. In contrast, he has strong family and other connections in Sri Lanka.

84. We have already found that there is insufficient evidence before us to show that the appellant's medical condition is sufficiently severe as to engage the operation of Article 3. In the absence of any other significant factors, the threshold is equally demanding for the purpose of Article 8. We conclude that the evidence relating to his medical condition is not strong enough to show that his removal would breach his right to private life (physical and moral integrity) in a sufficiently grave way to amount to a disproportionate breach of Article 8.

85. We conclude that, on the basis of the evidence before us, the removal of the appellant would not be unlawful under section 6 of the Human Rights Act 1998.

86. We highlight that the Secretary of State's still has a responsibility to ensure that the appellant is assessed by a qualified medical professional before any enforcement action is taken.

DECISION

The First-tier Tribunal DISMISSED the appeal on Refugee Convention grounds

The appeal is also DISMISSED on human rights grounds

Signed M. Canavan Date 12 September 2022

Upper Tribunal Judge Canavan

NOTIFICATION OF APPEAL RIGHTS

1. A person seeking permission to appeal against this decision must make a written application to the Upper Tribunal. Any such application must be **received** by the Upper Tribunal within the **appropriate period** after this decision was **sent** to the person making the application. The appropriate period varies, as follows, according to the location of the individual and the way in which the Upper Tribunal's decision was sent:

2. Where the person who appealed to the First-tier Tribunal is **in the United Kingdom** at the time that the application for permission to appeal is made, and is not in detention under the Immigration Acts, the appropriate period is **12 working days (10 working days, if the notice of decision is sent electronically).**

3. Where the person making the application is in detention under the Immigration Acts**, the appropriate period is 7 working days (5 working days, if the notice of decision is sent electronically)**.

4. Where the person who appealed to the First-tier Tribunal is **outside the United Kingdom** at the time that the application for permission to appeal is made, the appropriate period is **38 days (10 working days, if the notice of decision is sent electronically).**

5. A "working day" means any day except a Saturday or a Sunday, Christmas Day, Good Friday or a bank holiday.

6. The date when the decision is "sent' is that appearing on the covering letter or covering email

ANNEX

Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: PA/00682/2019

THE IMMIGRATION ACTS

Heard at Field House
on 12 January 2022

Decision Promulgated

.....

Before

UPPER TRIBUNAL JUDGE CANAVAN

Between

A R
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Anonymity
Rule 14: The Tribunal Procedure (Upper Tribunal) Rules 2008
Anonymity was granted at an earlier stage of the proceedings because the case involves protection issues. I find that it is appropriate to continue the order. Unless and until a tribunal or court directs otherwise, the appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him or any member of his family. This direction applies both to the appellant and to the respondent.

Representation:
For the appellant: Mr J. Martin, instructed by Indra Sebastian Solicitors
For the respondent: Mr D. Clarke, Senior Home Office Presenting Officer

DECISION AND REASONS

1. The appellant appealed the respondent's decision dated 19 November 2018 to refuse a protection and human rights claim.

2. There has been a long procedural history to this appeal, but it is not necessary to set it out for the purpose of this decision. The decision that is the subject of this appeal is the decision of First-tier Tribunal Judge Wylie, which was promulgated on 30 June 2021. She dismissed the appeal on protection and human rights grounds.

3. The appellant did not apply for permission to appeal the decision relating to the protection claim, but argued that the judge failed to give adequate reasons and/or failed to have regard to relevant evidence when making her findings relating to Article 3 (suicide risk) and Article 8 more generally.

4. The parties agreed that the decision involved the making of an error of law. Mr Clarke said that the judge failed to consider the express finding of Dr Lawrence that the appellant's family would not be a sufficiently protective factor if he returned to Sri Lanka when she concluded at [156] that they would be. He was also concerned that the judge failed to consider how, even if the appellant was not likely to be at objective risk on return, his intense subjective fear would impact on the risk of a severe deterioration in his mental health on return. Although the judge referred to the decision in *J v SSHD* [2005] EWCA Civ 6329, she failed to take into account the modification relating to subjective fear outlined in the subsequent decision of *Y (Sri Lanka) v SSHD* [2009] EWCA Civ 362. It was agreed that the errors in the assessment of the evidence also undermined any findings made in relation to Article 8. I agreed with the parties that these points disclosed errors for the reasons given.

5. The First-tier Tribunal decision relating to the Article 3 (medical) claim and the Article 8 claim involved the making of errors on points of law. Those parts of the decision are set aside and will be remade at a resumed hearing.

6. The parties agreed that the decision should be remade in the Upper Tribunal. Although the appellant is a vulnerable witness who is unlikely to give evidence, the medical evidence is now out of date. It was in the interests of justice to remake the decision on another date in order to allow time for up to date evidence to be produced.

7. The scope of the remaking will be confined to Article 3 (medical) and Article 8.

DIRECTION

8. **The parties** shall file and serve any up to date evidence relied upon at least 14 days before the next hearing.

DECISION

The First-tier Tribunal decision involved the making of an error of law

The decision relating to Article 3 (medical) and Article 8 is set aside

The decision relating to the protection claim shall stand

Signed M. Canavan Date 12 January 2022

Upper Tribunal Judge Canavan