



**IN THE UPPER TRIBUNAL**  
**IMMIGRATION AND ASYLUM CHAMBER**

**Case No: UI-2022-001983**  
**First-tier Tribunal No:**  
**RP/50010/2021**  
**LR/00028/2022**

**THE IMMIGRATION ACTS**

**Heard at Field House IAC**  
**On the 30 November 2022**

**Decision & Reasons Promulgated**  
**On the 15 February 2023**

**Before**

**UPPER TRIBUNAL JUDGE FRANCES**  
**DEPUTY UPPER TRIBUNAL JUDGE FROMM**

**Between**

**M B**  
**(ANONYMITY DIRECTION MADE)**

Appellant

**and**

**THE SECRETARY OF STATE FOR THE HOME DEPARTMENT**

Respondent

**Representation:**

For the Appellant: Mr P Turner, Imperium Chambers

For the Respondent: Mr S Walker, Senior Home Office Presenting Officer

**DECISION AND REASONS**

1. The appellant is a citizen of Algeria born in 1993. His appeal against the refusal of his protection claim was allowed by First-tier Tribunal Judge Morgan ('the judge') on 21 March 2022 on human rights grounds. This

decision was set aside for the reasons given in the decision of Upper Tribunal Judge Frances (the 'UTJ') dated 5 October 2022. The appeal was adjourned for re-hearing before the Upper Tribunal.

### **Relevant facts**

2. The appellant's immigration history set out below is taken from the appellant's skeleton argument. There was no dispute on the facts raised in the appeal before us. The appellant left Algeria in October 2016 and initially travelled to Turkey. He then travelled through Europe and arrived in Germany in November 2015. He claimed asylum in Germany but was refused. He left Germany in August 2016 and arrived in the UK on 25 August 2016 through Belfast.
3. The appellant claimed asylum in the UK and was interviewed on 26 August 2016. There was no interpreter present. He initially informed immigration officials that he was a minor but later confirmed his correct age. He was detained on 27 August 2016. On 28 August 2016, he attended a screening interview in relation to his asylum claim. The appellant was released on 30 August 2016 and placed on reporting conditions. He ceased reporting on 4 October 2016 and his asylum claim was withdrawn by the Home Office on 27 January 2017.
4. On 18 September 2018, the appellant was arrested and interviewed by immigration officers having boarded a flight from Girona to Stanstead. He had travelled to Spain to visit his uncle who was having surgery. He was convicted on 18 October 2018 of possession/control of identity documents and sentenced on the same day to 12 months' imprisonment.
5. On 25 October 2018, the appellant was sent a notice of decision to make a deportation order. This was served on 26 October 2018. On 21 November 2018, the appellant submitted representations against the deportation order and on 3 January 2019, he submitted further representations stating he wanted to claim asylum in the UK. On 28 June 2019, a substantive asylum interview took place. On 16 September 2020, the appellant's protection and human rights claim was refused.

### **Issues**

6. The judge's finding at [21] was preserved:

"Whilst the appellant's subjective fear is genuine, it is difficult to find, even applying the lower standard, that it is well founded or that there is not an internal relocation alternative."
7. The UTJ found the judge failed to apply the sixth question in J or to consider [39] of Y because he made no finding on whether the appellant could access

treatment on return and/or whether, with the support of his family, the risk of suicide could be kept under control. The judge failed to consider whether there were effective mechanisms in Algeria to reduce the risk of suicide. The judge failed to apply the high threshold in AM (Zimbabwe) v SSHD [2020] UKSC 17.

8. Given the preserved finding, the appellant could return to his home area. He was not at risk from his family or Mr Ali on return to Algeria, notwithstanding his subjective fear was genuine. The issues before us are whether the appellant could access appropriate treatment on return and whether the risk of suicide could be kept under control.
9. The appellant relied on the bundle of documents before the First-tier Tribunal ('AB') and a supplementary bundle of 142 pages ('ASB') including a medico legal report of Michael Smyth, a consultant psychologist, dated 14 November 2022 ('the expert report') and background evidence of psychiatric services in Algeria.

### **Relevant law**

10. In J v SSHD [2005] EWCA Civ 629, the Court of Appeal set out the relevant Article 3 test in suicide cases at [26] to [31] which is summarised below:
  - (i) 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.
  - (ii) 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.
  - (iii) Thirdly, in the context of a foreign case, the article 3 threshold is particularly high simply because it is a foreign case.
  - (iv) Fourthly, an article 3 claim can in principle succeed in a suicide case (para [37] of *Bensaid*).
  - (v) 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.
  - (vi) 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.

11. In Y and Z v SSHD [2009] EWCA Civ 362, the Court of Appeal considered the fifth principle in J and added to it as follows

“14. ...If a fear of ill-treatment on return *is* well-founded, this will ordinarily mean that refoulement (if it is a refugee convention case) or return (if it is a human rights case) cannot take place in any event. In such cases the question whether return will precipitate suicide is academic. But the principle leaves an unfilled space for cases like the present one where fear of ill-treatment on return, albeit held to be objectively without foundation, is subjectively not only real but overwhelming.

15. There is no necessary tension between the two things. 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.

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.”

...

“38. Both cases therefore come, in my judgment, within the ancillary principle set out in §16 above.

39. What remains is the question whether, if returned, the appellants will have access to care and treatment which will keep the risk of self-harm under control.”

12. In AM (Zimbabwe) v SSHD [2020] UKSC 17, the Supreme Court considered the decision of the European Court of Human Rights ('ECtHR') in Paposhvili v Belguim [2017] Imm AR 867 in which the ECtHR stated at [183]:

“The Court considers that the ‘other very exceptional cases’ within the meaning of the judgment in N v The United Kingdom (para 43) which may raise an issue under article 3 should be understood to refer to situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy. The Court points out that these situations correspond to a

high threshold for the application of article 3 of the Convention in cases concerning the removal of aliens suffering from serious illness.”

13. At [32] of AM (Zimbabwe) the Supreme Court held:

“It is clear that, in application to claims under article 3 to resist return by reference to ill-health, the Grand Chamber has indeed modified that principle. The threshold, set out in para 23(a) above, is for the applicant to adduce evidence “capable of demonstrating that there are substantial grounds for believing” that article 3 would be violated. It may make formidable intellectual demands on decision-makers who conclude that the evidence does not establish “substantial grounds” to have to proceed to consider whether nevertheless it is “capable of demonstrating” them. But, irrespective of the perhaps unnecessary complexity of the test, let no one imagine that it represents an undemanding threshold for an applicant to cross. For the requisite capacity of the evidence adduced by the applicant is to demonstrate “substantial” grounds for believing that it is a “very exceptional” case because of a “real” risk of subjection to “inhuman” treatment. All three parties accept that Sales LJ was correct, in para 16, to describe the threshold as an obligation on an applicant to raise a “prima facie case” of potential infringement of article 3.”

14. HA (expert evidence; mental health) Sri Lanka [2022] UKUT 00111 (IAC), the Tribunal held:

- (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.
- (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.
- (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.

## **Submissions**

15. Mr Turner relied on his skeleton argument dated 15 November 2022 and took us through the expert report in some detail. He referred to the letter of instruction and submitted the expert report should be given considerable weight.
16. The appellant's subjective fear was accepted and he heard the voice of Mr Ali stating: "I will kill you". As a result, the appellant moved from place to

place to avoid Mr Ali. The appellant was at high risk of suicide and it was apparent from the consistent medical evidence that his mental ill health is long-standing and he refused to seek help. The appellant refused to engage with treatment and would not seek support from his family who would be unable to prevent the risk of suicide in any event. The appellant was at high risk of suicide in the UK which would be exacerbated on return to Algeria.

17. Mr Turner submitted the expert report was not premised on the matters relied on in the paragraphs entitled “NOTA BENE: Summary of Crucial Case factors”. The appellant believed Mr Ali had a close connection with the Algerian state and family support was irrelevant given the appellant’s subjective fear.
18. Mr Turner submitted on the evidence before the Upper Tribunal the appellant satisfied the sixth principle in *J* and met the high threshold in *AM (Zimbabwe)*. The expert specifically addressed the relevant issues identified in the error of law decision and relied on the evidence of Zoubir Benmebarek in his country profile article dated February 2017 which was also referred to in the respondent’s CPIN ‘Algeria: Internal relocation and background information’ dated September 2020 (‘CPIN’).
19. Mr Turner submitted it was clear from the expert report that treatment was not available to the appellant and he would not access it. Mental health services were severely lacking in Algeria and the respondent had failed to show the appellant could access treatment for his mental health condition. There was no evidence to show the appellant would be able to access the limited services available to him. There was no treatment in the community in Algeria and the appellant’s condition would worsen on return. He was at high risk of suicide and the appeal should be allowed on Article 3 grounds.
20. Mr Walker submitted the appellant had access to medical care in Algeria in 2010 and his family had access to medical care. The appellant’s father had similar mental health problems. The appellant could return to his family in Algeria and access appropriate treatment. The expert report did not deal with support from the appellant’s family or their ability to access health services in Algeria. Treatment for the appellant’s mental health condition was available to the appellant and there was no reason why he could not access it as he had done prior to coming to the UK. He could return to his home area and obtain the same level of support and access to treatment as his family. Mr Walker accepted the diagnosis in the expert report. He submitted on the evidence there would be no breach of Article 3.
21. In response, Mr Turner submitted there was no evidence the appellant’s family were receiving treatment in Algeria and the appellant’s mental health condition was extremely unusual and well documented. He feared the government because he believed they were connected to Mr Ali. The appellant would not stay with his family given this fear and he had moved around Algeria in 2010. His mental health had deteriorated and his family

had been unable to assist him in the past. The appellant met the tests in J and AM (Zimbabwe).

### **Expert report**

22. Mr Smyth assessed the appellant by video link for 80 minutes on 9 November 2022. He stated that he had sight of various legal, health and immigration documents including but not limited to the solicitor's instructions, the appellant's witness statements, the decisions of the First-tier Tribunal and Upper Tribunal, the report of Dr Bashir dated August 2021, the psychiatric brief of Dr Attabi dated August 2021, land agreements and judgment in Algeria and the Home Office Bundle.
23. Mr Smyth described three psychometric tests including the 'Columbia Suicide Scale (C-SSRS) at section C3 of the expert report (page 26 ASB):

"The C-SSRS demonstrated good convergent and divergent validity with other multi-informant suicidal ideation and behaviour scales and had high sensitivity and specificity for suicidal behaviour classifications compared with another behaviour scale and an independent suicide evaluation board. Both the ideation and behaviour subscales were sensitive to change over time. The intensity of ideation subscale demonstrated moderate to strong internal consistency. In the adolescent 'suicide attempters' study, worst-point lifetime suicidal ideation on the C-SSRS predicted suicide attempts during the study, whereas the Scale for Suicide Ideation did not. Participants with the two highest levels of ideation severity (intent or intent with plan) at baseline had higher odds for attempting suicide during the study.

These findings suggest that the C-SSRS is suitable for assessment of suicidal ideation and behaviour in clinical and research settings.

"The Columbia-Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings."

(Kelly Posner, et al, et al. Am J Psychiatry. 2011 Dec; 168(12): 1266-277.doi: 10.1176/)

24. At page 40 ASB, Mr Smyth noted the appellant reported feeling lonely, isolated and confused and has suffered suicidal ideation regularly. At page 41 Mr Smyth stated:

"In July 2021 [the appellant] was reviewed by a psychiatrist who had been caring for him since 2010 who reported:

'I have been following the above named since 2010 January/July 2015 for a 100% a disabling chronic psychiatric condition ..... schizotypal with a bipolar component with a chronic psychiatric form of schizopathic type ..... of schizophrenia ....., with decompensation and bipolar manic and depressive disorders with behavioral disorders and suicidal tendencies'.



(Les Vergers Health Center, Dr. Attabi, Psychiatrist.)’”

25. At pages 44/45 ASB, it stated:

“He also exhibits some psychosomatic symptoms of anxiety such as, sweating excessively, rapid heartbeat, weak joints, indigestion, back pain, feeling faint, hands trembling and numbness or tingling and oftentimes fidgety and paranoid. “I have no future left; I would rather be dead than alive!” he exclaimed.

[The appellant] dreads return to Algeria and is always fearing the worst may happen. (paranoia). He reported that he is frightened saying, “I feel like my heart is sinking slowly!” He feels that he is a failure as he cannot work, he is now dependent on friends, and his future seems hopeless. He reported levels of active suicidal ideation.”

26. At pages 46/47 ASB, Mr Smyth stated:

“He is currently in the grip of a chronic depression and suffers regular suicidal ideation, “Everything is dark in front of me, I will die here!” he said.

[The appellant] is plagued by fear, he implies that the world is against him. Dr. A. Bashir’s Psychiatric Report of Aug ’21 noted, ‘He ([the appellant]) presents with persecutory delusions, ideas of reference and third person auditory hallucinations with thoughts broadcasting. He suffers from paranoid hallucinations which remain untreated.’

[The appellant] is convinced that he will be killed if he goes back to Algeria. He indicated that if sent back to Algeria he would better kill himself before being caught by Mr Ali Maamri.

He has managed to stay safe and survived through various stressors while living in the UK with his friends and more recently GP’s support via attending group therapy. His prognosis will be worse if he returns to Algeria as he is likely to hide and continue to move from place to place. He was diagnosed with Paranoid Schizophrenia (ICD 10: F20.0) in Aug ’21 and still exhibits exaggerated paranoia and persecutory delusions hence would be vulnerable and exposed to the effects of suicidal ideations if he was returned to Algeria.

His father suffered from chronic psychotic illness and it is therefore not unusual that a son exhibits some features of his chronic illness. He has been plagued by suicidal thoughts since his youth following his trauma under the threats and attacks of Mr. Ali. He reported that some years back he suffered suicidal thoughts in Algeria and went to stand on a high bridge, but locals came and coaxed him down again. The suicidal thoughts are currently secondary but are unremittingly driven by his paranoia.”

27. Mr Smyth stated at page 54 ASB:

“He expressed regular active suicidal ideation and admitted to having intent. When I asked had he thought about how he might end his life he replied matter of factly, ‘I will throw myself in front of a train at London Bridge!’”

28. At pages 59/60/61 ASB, it stated:

“The ongoing uncertainty and instability in his life make recuperation more difficult and drive his suicidal ideation. [The appellant] reported that his good friend ‘Najib’ who was living in the UK, committed suicide in 2020. ‘I was devastated and thought at the time that there really is no reason why I shouldn’t join him!’

[The appellant] reported ongoing active intent of self-harm/suicide, saying he sometimes reflects that would like to kill himself. “This is not a life. I can’t stay like this forever!”

...

“[The appellant’s] regular thoughts of suicide/self-harm, his mood dysregulation, self-deprecation and shame, current confusion, derealization, delusions and aural and visual hallucinations all contribute to the intensity of his distress and suicidal ideation.”

29. Under the section entitled “NOTA BENE” at pages 61 to 69 ASB it stated:

“[The appellant] has been living in the UK for the last six years and has built up social support and NHS mental health support for his chronic mental conditions, which he would not have access to in Algeria. Threat of deportation would put his life at risk.

...

[The appellant’s] regular suicidal ideation, mood dysregulation, hallucinations and delusions, self-deprecation, current confusion and fatigue, inability to control his life, paranoia, hyper-vigilance and occasional lapses of presence and concentration, place him at Severe Risk of Suicide/ self- harm.

Currently scoring 5/6 on the Colombia Suicide Rating Scale (see psychometric results) Indicates a high-risk factor to any prominent alterations in his currently supportive environment.

...

I note [the appellant’s] BPRS score of 81, as confirmation of his psychotic symptoms, his B.D.I. score of 53 as indicative of Extreme Depression, and his score of 5/6 in the Colombia Suicide Rating Scale(CSRS) indicates active and elevated suicidal ideation.

I strongly believe that urgent intervention is required in order to alleviate his currently fragile mental state.

[The appellant’s] previous history, coupled with his current conditions of Paranoid Schizophrenia and chronic Depression, place him at Serious Risk of self-harm or suicide.”

30. Mr Smyth was asked whether the appellant would be able to access adequate mental health treatment in Algeria. He stated at pages 65/66 ASB:

“In my opinion the psychological, social, and physical conditions for [the appellant’s] chronic schizophrenic and depressive state to be adequately addressed, are not currently in place should he return to Algeria where his perceived greatest threats lie.

...

Adequate mental health care is in its infancy in Algeria and people suffering Mental Health issues are often viewed as cursed, such people are ostracized and sometimes beaten or receive abuse rather than medical assistance.”

31. At page 69ASB it stated:

“I would judge from his presentation, previous history, and current state of mind that without speedy interventions and changes in his personal circumstance [the appellant] is currently at Serious risk of self-harm or suicide.

And at page 71 ASB, Mr Smyth recommended the appellant’s treatment be undertaken in a community mental health setting.

32. The Columbia-Suicide Severity Rating Scale is at page 78 ASB. It addresses six questions.

- 1) Wish to be dead – have you wished you were dead?
- 2) Suicidal thoughts – have you had any actual thoughts of killing yourself?
- 3) Suicidal thoughts with method (without specific plan or intent to act) – have you been thinking about how you might do this?
- 4) Suicidal intent (without specific plan) – have you had these thoughts and had some intention of acting on them?
- 5) Suicidal intent with specific plan – have you started to work out the details of how to kill yourself. Do you intend to carry out this plan?
- 6) Suicide behaviour question – have you ever done anything to end your life within the last three months?

Mr Smyth recorded ‘yes’ to questions 1 to 5.

### **Background evidence**

33. The CPIN dated September 2020 stated at paragraph 12 that the health care system has posted impressive results in making care available and accessible. The health care system was reorganised to bring health care structures closer to the people. In relation to mental health it stated at 12.2.2 (page 108 ASB):

“The mental health sector in Algeria is excessively reliant on psychiatric hospitals and inpatient care. Instead of building new psychiatric hospitals, each general hospital should have an inpatient psychiatric unit to make mental health care more accessible to all and avoid stigmatization. Although the availability of mental health services in primary-care centres has increased in recent years, with 129 centres providing such services, additional steps should be taken to reinforce outpatient services within general hospitals and reduce dependency on hospital care. There should be a shift in mental health services and public investments in the community, with initiatives grounded in human rights and modern principles of mental health policy and based on quality services and the empowerment of users.’

12.2.3 For an overview of the Mental Healthcare, see:

- WHO, Mental Health Atlas – 2017, country profiles
- Psychiatric services in Algeria, February 2017, by Zoubir Benmebarek”

34. The Country Profile report: Psychiatric services in Algeria by Zoubir Benmebarek stated at pages 134/135 ASB:

“The state provides psychiatric care free of charge. There are no private psychiatric hospitals in Algeria (Kacha, 2005, 2010). Most psychotropic drugs – even atypical antipsychotics – are available free of charge for people who have a chronic mental illness.

...

Of the 13 university hospitals, six have a department of psychiatry; there are 16 mental health specialist hospitals and 13 psychiatric wards in general hospitals (Zahir, 2012)

...

Out-patient psychiatric care is predominantly provided at psychiatric dispensaries (called intermediate centres of mental health) by a psychiatrist and a nurse. They are located in cities and towns and cater for a geographical catchment area. The number of these centres is uneven across the country; large cities are better provided for than remote areas. Out-patient care is limited to providing consultation, and no other form of community care is available for adults; there are no community residential rehabilitation programmes.

...

The mental health legislation is based on the 1985 Mental Health Law, which primarily deals with various forms of hospitalisation. The Health Department launched a mental health programme in 2001 to improve the quality and efficiency of psychiatric care. There is an ongoing effort to reshape mental healthcare services, including reviewing legislation, decentralisation, integration of psychiatry into the primary care system and developing rehabilitation programmes.”

## **Conclusions and reasons**

35. The appellant's records from HMP Maidstone dated March 2019 refer to an entry on Monday 17 December 2018 (page 344 AB) in which the appellant informed the GP that he had no history of psychotic disorders and no previous hospital admissions for mental health disorders. The appellant reported he saw his GP in Algeria for talking therapies regarding anxiety disorders. The appellant denied thoughts of deliberate self-harm, suicidal ideation or intention. The appellant stated his family were a protective factor. The appellant had experienced fleeting thoughts back in 2013 when he had contemplated throwing himself in a river from a bridge, but he had been talked down by a passer-by. The appellant reported no incidents since then. He stated he was from a large family with whom he was in contact save for one brother. The appellant was not on medication at that time. He was subsequently prescribed Sertraline for depression.
36. We attach little weight to the expert report of Dr Bashir dated 31 August 2021. He interviewed the appellant without an interpreter on 18 July 2021. Dr Bashir accepted the appellant's English comprehension was poor and it was difficult for the appellant to communicate. Dr Bashir referred to a suicide attempt in 2015 when the appellant claimed he was spotted trying to jump from a hill. There was no reference to this in the appellant's witness statement, the records from HMP Maidstone or in the expert report of Mr Smyth. Dr Bashir referred to "medical notes from Chelmsford prison", but these were not in the appellant's bundles.
37. We attach little weight to the report of Mr Smyth. It is clear from the paragraphs of the report set out above that the report is repetitive and incomprehensible in relation to the psychometric test on suicide. There was no apparent evidential basis for the conclusions in the report and no reference to the GP notes from HMP Maidstone. The report relied on the opinion of Dr Bashir and referred to a translation of a medical prescription in Algiers dated 7/7/2021 which made no sense whatsoever given the appellant left Algeria in 2016 (see [24] above and page 92 AB).
38. We find the expert report is based on a misapprehension of the facts. The section entitled "NOTA BENE" not only repeats the previous sections but makes further conclusions based on erroneous findings. In our view, the expert has misunderstood the documentary evidence before him. The appellant does not have a well-founded fear of persecution in this case.
39. In addition, Mr Smyth was not an expert on the mental health facilities in Algeria and his opinion was inconsistent with the background evidence. His conclusions in his report had no evidential basis and did not comply with HA (Sri Lanka).
40. The respondent accepted the appellant suffered from paranoid schizophrenia and does not challenge this diagnosis. However, the issue in

this appeal is whether the appellant will have access to care and treatment in Algeria which will keep the risk of self-harm/suicide under control.

41. Mr Smyth's conclusion that the appellant is at high risk of suicide is based on the six questions asked in the C-SSRS. It is apparent when considering the account given by the appellant in relation to suicide ideation that he has no plans to commit suicide. The appellant does not address this in his witness statement. Mr Smyth's assessment on the risk of suicide is not supported by the evidence before us.
42. Having considered the totality of the evidence, there is mental health treatment available in Algeria and the appellant has accessed it prior to coming to the UK. He currently is not in receipt of treatment in the UK and there is insufficient evidence to show that he is at risk of suicide. The appellant's evidence is that he attempted suicide in 2013 in Algeria. There have been no suicide attempts since then, notwithstanding his evidence that he hears Mr Ali's voice threatening to kill him and he believes two accomplices are following him and are trying to get him deported (page 41 ASB).
43. The background evidence demonstrates there is treatment available in Algeria. The appellant has a large family there to provide support. On the totality of evidence, we find there are effective mechanisms to reduce the risk of suicide in Algeria. The appellant would have access to treatment and support to keep the risk of suicide under control. The appellant's removal to Algeria would not breach Article 3.
44. We dismiss the appellant's appeal.

## **Notice of Decision**

### **Appeal dismissed**

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

**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.**

**J Frances**

Signed  
Upper Tribunal Judge Frances

Date: 9 December 2022

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**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.