



IN THE UPPER TRIBUNAL
IMMIGRATION AND ASYLUM CHAMBER

Case No: UI-2022-004812
First-tier Tribunal No: PA/56168/2021
IA/18282/2021

THE IMMIGRATION ACTS

**Decision & Reasons Issued:
On 11th March 2024**

Before

UPPER TRIBUNAL JUDGE BRUCE

Between

**PJ
(Anonymity order made)**

and

Secretary of State for the Home Department

Appellant

Respondent

Representation:

For the Appellant: Mr Caswell, Counsel instructed by Sriharans Solicitor
For the Respondent: Mr Tan, Senior Home Office Presenting Officer

Heard at Manchester Civil Justice Centre on 14 November 2023

DECISION AND REASONS

1. The Appellant is a national of Sri Lanka born in 1969. He seeks leave to remain in the United Kingdom on human rights grounds.
2. His appeal first came before me on the 22nd February 2013 when he brought, with permission, a challenge against the decision of the First-tier Tribunal (Judge Saffer) to dismiss his appeal on human rights grounds.
3. The core of the Appellant's case before Judge Saffer was that if returned to Sri Lanka he would face a serious, rapid and irreversible decline in his mental health and general living conditions such that would result in intense suffering and/or a loss of life and thereby violate the United Kingdom's obligation under Article 3 ECHR. The substance of that claim was that the Appellant is living with paranoid schizophrenia. He had for many years received treatment for that condition in Sri Lanka, but the situation there had markedly changed. An

economic crash had led to a concomitant collapse in the provision of healthcare; the drugs that he takes to manage his condition are no longer available to buy or are prohibitively expensive; his father had died, and his mother is elderly and unable to offer support; his brother cannot provide for him; he is estranged from his own family and his ex-wife does not allow him any contact with his son. The Appellant relied on a medical report from Consultant Psychiatrist Dr Saleh Dhumad who was of the opinion that if returned to Sri Lanka his “mental health will deteriorate very quickly after stopping his medication for a few days, and it is likely he will take his own life”.

4. In the alternative the Appellant argued on the same facts that the refusal to grant him leave would result in a disproportionate interference with his Article 8 rights: he placed particular reliance on paragraph 276ADE(1)(vi) of the Immigration Rules which provides that leave will be granted where it can be shown that there are “very significant obstacles” to his integration in Sri Lanka. Although this is not now a matter before me, I note that the Appellant also pursued protection grounds before the First-tier Tribunal. The appeal was dismissed on these grounds and the Appellant makes no onward challenge to that.
5. The Respondent did not dispute that the Appellant suffers from paranoid schizophrenia. She was however of the view that the medication that he requires would be available to him in Sri Lanka and that he would there receive the care he needs to ensure that he does not suffer a catastrophic decline in his mental well-being. He left Sri Lanka as an adult and is familiar with the culture and society. He still has family members there. No violation of his human rights would therefore occur if he were to leave the UK.
6. Judge Saffer agreed with the Respondent, and dismissed the appeal.
7. The Appellant appealed against that decision on the grounds that in doing so Judge Saffer failed to take material evidence into account, and/or conducted an impermissibly narrow reading of the evidence before him, in particular that relating to the availability of medicines in Sri Lanka. The Respondent contended that the Tribunal had taken all available evidence into account and was entitled to reach the decision that it did. This was the matter in issue at the hearing before me in February, when the Respondent was represented by Senior Presenting Officer Ms Z. Young. For reasons that I set out below under the heading ‘error of law’ I found that the First-tier Tribunal had erred in its approach and that its decision must be set aside. I gave instructions that the matter be relisted before me. Unfortunately there was then a significant delay, the matter being adjourned on at least two occasions. The hearing resumed on the 14th November 2023 and the parties made submissions relying, where appropriate, on new evidence about the Appellant’s mental health and availability of care in Sri Lanka. I reserved my decision which I now give, under the heading ‘the decision re-made’ below.

Error of Law

8. The argument before me centred on the following passage in the First-tier Tribunal’s decision:
 9. Dr Dumad does not indicate in his CV any knowledge of the health system in Sri Lanka. There is no evidence he has spoken to a colleague

in Sri Lanka or visited Sri Lanka. The background evidence relied on is limited. It amounts to part of an article in the British Medical Journal (29 June 2022 - it is only part as it is a subscription service) and an article in the Guardian (31 May 2022). The articles do not refer to medication used to treat psychiatric illnesses not being available. They refer to 80% of the medication being imported. That means 20% is not. It does not refer to what stock is available, but there is plainly some as prices have increased. Nor is the information current as the articles are 5 weeks old and 9 weeks old respectively. It has not been established what humanitarian efforts to deliver medication in the last few weeks have occurred.

9. Read with this:

32. Dr Dumad has asserted that the mental health support in the United Kingdom is far more advanced and inclusive than Sri Lanka. However the background evidence makes it clear that prior to the recent difficulties in Sri Lanka there was excellent mental healthcare provision in Sri Lanka which the appellant accessed in 1999 through a 4 month in patient stay and medication and it is clear from the CPIN that it has developed since then. Dr Dumad does not explain what source he has accessed upon which to base his opinion. Dr Dumad asserts that the appellant is not fit to fly, but he has not considered what additional mechanisms can be put in place to ameliorate the risk before and during the process. I accept that the fear is delusional and unshakable and has not settled despite treatment in the United Kingdom, However, as it has not been established that there is real risk that there will be a withdrawal of medication, there is no risk there would be a swift decline in his mental health.

10. Mr Caswell submitted that these passages reveal a fundamental error in approach. The CPIN referred to by the Tribunal was the July 2020 document *Sri Lanka: Medical Treatment and Healthcare*, which is summarised in the decision as detailing “the provision of treatment, medication, and access to specialist hospitals and community services and its provision in public and private sectors”. As I read it, it is this evidence that the Tribunal relies upon when it refers elsewhere to “the extensive infrastructure shown to have been created in Sri Lanka for treatment and support”. That evidence, all obviously pre-dating the publication of the CPIN in July 2020, is consonant with the Appellant’s own evidence that he had received adequate treatment for his condition before he left Sri Lanka in 2009.
11. Absent a change in circumstance, the Tribunal would have been quite entitled to find on the basis of this evidence that the Appellant would have access to treatment in Sri Lanka today. The complaint made on the Appellant’s behalf was however that there *has* been such a change in circumstance, that the Tribunal failed to recognise that fact, and diminished the evidence of it in an unreasonable manner.
12. The evidence before the Tribunal adduced on the Appellant’s behalf consisted of three documents. The first was part of an article from the British Medical Journal dated the 29th June 2022: it was incomplete, because as the Tribunal observed, the rest of it appeared to be behind a paywall. The part that could be seen nevertheless referred to the “devastating health consequences of Sri Lanka’s economic collapse”. The second was an article from the Guardian dated 31st May 2022. I need only set out the headline to convey a flavour of the report: “People are going to die: Crisis-hit Sri Lanka runs out of medicine”. The

third was another article from the Guardian, this time dated 5th August 2022 and reporting that martial law had been declared in a response to protests about the collapse of the economy. Mr Caswell pointed out that none of this evidence was contentious. Although none of it squarely addressed the availability of the particular drugs that the Appellant takes to manage his condition, it could – in Mr Caswell’s submission should – have reasonably been inferred from this evidence that it would now be very difficult for him to obtain that medication. The articles conveyed a clear picture: that the Sri Lankan health sector was experiencing a sudden and overwhelming collapse, brought on by the economic crisis facing the country in the summer of 2022.

13. It cannot be said that the Tribunal failed to take these articles into account. As Ms Young pointed out, it expressly addresses them in its decision. The difficulty is that I cannot be satisfied that in doing so it addressed itself to the correct question: was there a real risk that the Appellant would find himself without medication for a long enough period to suffer serious rapid and irreversible deterioration in his condition such that he would experience intense suffering or take his own life?

14. The Tribunal gives two reasons for apparently declining to place weight on the material submitted by the Appellant to counteract the optimistic picture painted by the July 2020 CPIN. The first, as I understand it, is that the articles do not expand in a satisfactory way on what drugs might still be produced in-country, so avoiding the difficulties surrounding payment of foreign currencies:

“The articles do not refer to medication used to treat psychiatric illnesses not being available. They refer to 80% of the medication being imported. That means 20% is not”.

If here the Tribunal intended to convey that there was a 20% chance that the Appellant could still get his medication, this is a conclusion difficult to square with the applicable standard of proof. Nor was it clear from the evidence whether specialist psychiatric medication such as that required by the Appellant fell into that category.

15. The second reason given is this: “nor is the information current as the articles are 5 weeks old and 9 weeks old respectively. It has not been established what humanitarian efforts to deliver medication in the last few weeks have occurred”. This was, with respect, a curious approach. The Tribunal declined to place weight on uncontroversial evidence because it was a month or two out of date, and instead uncritically adopted the evidence in the CPIN, which was at the date of the hearing over two years old. The enquiry about what humanitarian aid might have arrived in the meantime was wholly speculative.

16. This error in approach is compounded by the failure to have regard to relevant findings by the Upper Tribunal. The last time that a country guidance panel considered the availability of psychiatric care in Sri Lanka was GJ and others (post-civil war: returnees) Sri Lanka CG [2013] UKUT 00319 (IAC). The Tribunal allowed the appeal of the third appellant in that case on the grounds that his mental health condition gave rise to a real risk of violation of Article 3 on return to Sri Lanka because the evidence indicated that he would not receive appropriate care. The evidence cited by the panel was as follows:

454. The evidence is that there are only 25 working psychiatrists in the whole of Sri Lanka. Although there are some mental health facilities in

Sri Lanka, at paragraph 4 of the April 2012 UKBA Operational Guidance Note on Sri Lanka, it records an observation by Basic Needs that “money that is spent on mental health only really goes to the large mental health institutions in capital cities, which are inaccessible and do not provide appropriate care for mentally ill people”.

455. In the UKBA Country of Origin Report issued in March 2012, at paragraph 23.28-23.29, the following information is recorded from a BHC letter written on 31 January 2012:

“ 23.28 The BHC letter of 31 January 2012 observed that: “There are no psychologists working within the public sector although there are [sic] 1 teaching at the University of Colombo. There are no numbers available for psychologists working within the private sector. There are currently 55 psychiatrists attached to the Ministry of Health and working across the country.”

17. The subsequent country guidance given in KK and RS (Sur place activities: risk) Sri Lanka CG [2021] UKUT 00130 (IAC) said nothing to the contrary. The guidance in KK and RS begins: *“In broad terms, GJ and Others (post-civil war: returnees) Sri Lanka CG [2013] UKUT 00319 (IAC) still accurately reflects the situation facing returnees to Sri Lanka. However, in material respects, it is appropriate to clarify and supplement the existing guidance, with particular reference to sur place activities...”*. Nowhere in the clarification and supplement that follows are the GJ findings on the paucity of mental health care in Sri Lanka addressed. It should be noted that the panel in KK and RS specifically had regard to the evidence in the July 2020 CPIN referred to by the First-tier Tribunal in this case.
18. For those reasons I was satisfied that the decision of the First-tier Tribunal must be set aside, and so ordered by my decision of the 15th March 2023.

The Decision Re-Made

19. There are a range of possible outcomes for the Appellant should be returned to Sri Lanka. The best case scenario is that he is reunited with his brother, his elderly mother and other extended relatives. He may resume old friendships and make new ones. He will have access to the medicine, and crucially the other mental health support, that he so evidently requires to be able to cope with what is otherwise a serious, chronic and frightening medical condition. Should that scenario play out, it perhaps goes without saying that there would be no violation of the UK’s obligations under the European Convention on Human Rights if he is removed. On the other end of the spectrum lies another extreme: so terrified by the combination of his illness and his return to a country where he delusionally imagines people are trying to get him, he will take his own life. If I am satisfied that there is a real risk of this worse case scenario playing out, the appeal must be allowed on Article 3 grounds.
20. In between those two extremes lie a range of progressively more serious situations. It is in this middle ground that I start my analysis.

Article 8

21. I deal first with Article 8, because it seems to me that the undisturbed findings of fact made by Judge Saffer form a complete answer to the question

posed by the rules, and indeed by the jurisprudence. To resist removal under the Rules the Appellant would need to demonstrate that there were “very significant obstacles to his integration” in Sri Lanka. Judge Saffer expressly rejected the contention that the Appellant would not receive support from his brother, who lives and works in that country. The Appellant still has an elderly mother there, and presumably other extended relatives and old friends. He speaks Sinhalese, is familiar with the culture and social mores of the country, and there does not seem to me to be an arguable case that he faces any obstacles to his integration. Mr Caswell suggests that the obstacle would be his mental health, but the evidence shows that with the appropriate care and medication, the Appellant is stable enough to maintain other human relationships and look after himself. The friends he has in the UK support him; the friends he still has in Sri Lanka are so loyal they have in the past sent him money in the UK to help with his prescription costs. If his illness is properly managed, there are no significant obstacles to him re-establishing himself in Sri Lanka, and it cannot be said that his return there would constitute a disproportionate interference with his private life. It is only if his illness is not properly managed that there is a possibility that Article 8 might be engaged. To that extent this ground of appeal stands and falls with the analysis of the facts under Article 3.

Article 3: Mental Health

22. I turn then to what has been referred to before me as the ‘health claim’. That is the contention that if returned to Sri Lanka the Appellant will face a serious, rapid and irreversible decline in his mental health such that he will endure intense suffering of a level that would engage Article 3. This argument rests on the judgment of the European Court of Human Rights in Paposhvili v Belgium (App No. 41738/10), [2017] Imm AR 876, and approved by the Supreme Court in AM (Zimbabwe) [2020] UKSC 17. As I observed in Ainte (material deprivation, Article 3, AM Zimbabwe) [2021] UKUT 00203 (IAC) [at 56-61], health claims are, properly understood, a species of material deprivation case. They require the Tribunal to consider the consequences for the individual of the withdrawal of material support, in this case the medical regime that the Appellant benefits from in the UK.
23. In AM (Art 3; health cases) Zimbabwe [2022] UKUT 00131 (IAC), the final hearing of the case remitted from the Supreme Court, the Tribunal set out the correct approach when dealing with any health claim:
- (1) Has the person (P) discharged the burden of establishing that he or she is “a seriously ill person”?
 - (2) Has P 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
 - [a] to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering, or

[b] to a significant reduction in life expectancy”?

(3) The first question is relatively straightforward issue and will generally require clear and cogent medical evidence from treating physicians in the UK.

(4) The second question is multi-layered. In relation to (2)[ii][a] above, it is insufficient for P to merely establish that his or her condition will worsen upon removal or that there would be serious and detrimental effects. What is required is “intense suffering”. The nature and extent of the evidence that is necessary will depend on the particular facts of the case. Generally speaking, whilst medical experts based in the UK may be able to assist in this assessment, 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 and/or clinicians and/or country experts with contemporary knowledge of or expertise in medical treatment and related country conditions in the receiving state. Clinicians directly involved in providing relevant treatment and services in the country of return and with knowledge of treatment options in the public and private sectors, are likely to be particularly helpful.

(5) It is only after the threshold test has been met and thus Article 3 is applicable, that the returning state’s obligations summarised at [130] of Savran become of relevance - see [135] of Savran.

24. As to this latter point, in Savran says this:

130. As to whether those conditions were satisfied in a given situation, the Court emphasised that the national authorities were under an obligation under Article 3 to establish appropriate procedures allowing an examination of the applicants’ fears to be carried out, as well as an assessment of the risks they would face if removed to the receiving country (see *Paposhvili*, cited above, §§ 184-85). In the context of those procedures

(a) it is for the applicants to adduce evidence capable of demonstrating that there are substantial grounds for believing that, if the measure complained of were to be implemented, they would be exposed to a real risk of being subjected to treatment contrary to Article 3 (*ibid.*, § 186);

(b) where such evidence is adduced, it is for the returning State to dispel any doubts raised by it, and to subject the alleged risk to close scrutiny by considering the foreseeable consequences of removal for the individual concerned in the receiving State, in the light of the general situation there and the individual’s personal circumstances; such an assessment must take into consideration general sources such as reports of the World Health Organization or of reputable non-governmental organisations and the medical certificates concerning the person in question (*ibid.*, § 187); and the impact of removal must be assessed by comparing the applicant’s state of health prior to removal and how it would evolve after transfer to the receiving State (*ibid.*, § 188);

(c) the returning State must verify on a case-by-case basis whether the care generally available in the receiving State is sufficient and appropriate in practice for the treatment of the applicant’s illness so as

to prevent him or her being exposed to treatment contrary to Article 3 (ibid., § 189);

(d) the returning State must also consider the extent to which the applicant will actually have access to the treatment, including with reference to its cost, the existence of a social and family network, and the distance to be travelled in order to have access to the required care (ibid., § 190); and

(e) where, after the relevant information has been examined, serious doubts persist regarding the impact of removal on the applicant – on account of the general situation in the receiving country and/or their individual situation – the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the persons concerned so that they do not find themselves in a situation contrary to Article 3 (ibid., § 191).

25. The first of the questions posed in AM can be immediately answered in the affirmative, since the Respondent does not dispute that the Appellant is a seriously ill person. His NHS notes confirm that he has a diagnosis of paranoid schizophrenia. His symptoms vary but they can include: auditory and visual hallucinations, crippling anxiety, paranoid and delusional thinking, severe depression. The Appellant's condition is managed with medication but his GP notes from 2019 indicate that when he started to come off his medication he had a rapid relapse. He also receives weekly talking therapy at Hounslow hospital and has the support of friends, who are judged by his practitioner and Dr Dhumad to be a strong protective factor.
26. The second AM question comes in two stages. Stripping it down I must consider whether the Appellant will have access to his treatment in Sri Lanka, and if there are substantial grounds for believing that he won't, whether that will lead to him experiencing "intense suffering".
27. As I note above, at the date of the appeal before the First-tier Tribunal the contemporaneous evidence indicated that there had been a financial crisis in Sri Lanka which severely limited the ability of both the private and public sector to import medicines. Some medications were produced in-country but the evidence on what they were was scant. The evidence indicated that the health system was in a state of "collapse".
28. Since the First-tier Tribunal hearing the Respondent has produced a short report on the availability of medicine specifically in response to this appeal. This 'response to an information request' ('the Response') is titled 'Sri Lanka: Schizophrenia' and is dated the 19 April 2023. It states that the Respondent took advice from an unnamed consultant psychiatrist and senior lecturer at Faculty of Medical Sciences, University of Sri Jayewardenepura, Nugegoda, Sri Lanka. I return to this evidence below, but consider here the part of the Response relied upon by the Appellant. In response to the question "What if any impact does the current economic crisis in Sri Lanka have on the ability to access medication and the continuity of supply?" the country policy and information unit have responded as follows:

3.1.1 The Lancet, a weekly peer-reviewed general medical journal, noted in an article dated September 2022:

'Sri Lanka—once a role model for health and development—is currently in an economic crisis... Most importantly, the economic crisis has put national health care in jeopardy. Physicians and health-care workers are trying to keep the Sri Lankan health-care system afloat. However, the current crisis has led to a shortage of fuel affecting the supply of medical equipment and emergency transport of patients and health-care workers. Out of options, nurses are working double shifts because daily transport to work has become unaffordable. With stocks of essential medication reaching a record low, physicians are focusing on ways to procure crucial medication.

'Sri Lanka used to import most of its medication, but now with a shortage of foreign currency, the hopes of procuring more medication are low. During April, 2022, there was a 40% increase in the cost of medication. Adding to the woe, medication has become up to four times more expensive and unaffordable to many people. Although most hospitals in Sri Lanka are public, the increase in cost of medication would discourage people from using private hospitals and increase burden on the public sector, which might encourage health-care workers to emigrate from the country to seek better jobs.'

3.1.2 Reporting on Sri Lanka's Socio-Economic Crisis, ACAPS, a non-profit, nongovernmental project providing international, independent humanitarian daily monitoring and analysis of the situations in 150 countries, to support humanitarian aid workers, reported in December 2022:

'Sri Lanka imports more than 80% of its pharmaceutical supplies. Although some of the supplies were restocked after facing shortages following the start of the crisis, as at early October 2022, the country faced shortages in 150 essential medicines, including paracetamol saline, and medicines for heart attacks, out of the 300 registered ones in the country due to foreign exchange crunch. The price of generic drugs in the country has also increased significantly. The shortages have severely affected the healthcare system, which has been further worsened by the lack of fuel and long power cuts that have curtailed operational capacity.'

3.1.3 AsiaNews, an official press agency of the Catholic Church's Pontifical Institute for Foreign Missions (PIME), reported on 13 February 2023:

'Sri Lanka is facing a serious shortage of medical drugs due to low foreign exchange reserves that prevent imports; out of 300 basic medicines, about 160 are no longer available. Several health experts report that the Health Ministry advised hospitals to prioritise emergency cases and urgent surgeries and delay others, minimising routine operations to preserve supplies. Across the country, especially in the capital, drug shortages are getting worse day by day, while in rural areas, hospitals have posted notices asking patients to bring plasters, gauze and bandages.

'A senior Health Ministry official, who asked that his name not be used, explained that "many hospitals may be closed down," if the situation is not addressed immediately. Several anaesthesiologists who spoke to AsiaNews confirmed the information. "About 60 medicines are expected to be imported shortly. But these stocks may be sufficient only for two to three months," one of them said. Last week, at a press briefing, the Sri Lankan Medical Association noted that while there was "a shortage of

some essential drugs, there are no stocks at all of others” like “anaesthetics and pain management medicines.””

3.1.4 EconomyNext, a Sri Lankan economic, financial and political news service, reported on 15 February 2023:

‘Most Sri Lankan hospitals have run out of some essential drugs and the latest decision comes as the Health Ministry has failed to purchase anesthetic drugs on time due to lack of foreign currencies and inability to open letter of credit after the country declared sovereign debt default last year. Sri Lanka’s health sector is funded by taxpayers’ money, but revenue shortfall and the government’s inability to borrow externally in face of debt default have deprived the government of importing essential drugs...

‘Cabinet Spokesman Bandula Gunawardena when asked about the drug shortage said it was due to lack of adequate dollars. “The shortfall is being rectified gradually,” Gunawardena told the weekly cabinet news briefing on Tuesday.’

3.1.5 The Foreign Commonwealth and Development Office (FCDO), Foreign travel advice: Sri Lanka, 19 April 2023, noted:

‘The Sri Lankan healthcare system is under strain due to the ongoing economic situation in the country. Public hospitals may face shortages of imported medicines and medical equipment. Private hospitals are likely to have better supplies. Hospitals and other medical services may be affected by fuel shortages and power cuts.’

29. I have set out all the information provided in response to the question in order to illustrate that it has not been edited. The Appellant relies on all of this as being strongly supportive of the submissions rejected by the First-tier Tribunal. Mr Tan did not take issue with any of it, indeed he could not, for it was the evidence he had produced.
30. The information shows that during 2022 the economic collapse in Sri Lanka had a significant knock on effect for the health sector. 80% of medications were imported, and the financial crash meant that they became unaffordable. By April there had been a 40% increase in the costs of essential medications and stocks ran low in both private and public facilities. By October there were shortages reported of 150 such medications. Generic drugs increased significantly in cost. By February 2023 the situation had become markedly worse. 160 basic medicines were no longer available at all, and in rural hospitals patients were being asked to attend with their own supplies including bandages. Hospitals were facing closure, although the FCDO noted that the private sector may be faring better.
31. The medical evidence relating to the Appellant is that he needs a balance of three particular medications to remain mentally stable: the anti-depressant Sertaline, the anti-psychotic Haloperidol, and Trihexylpheidate, a drug prescribed with Haloperidol to help regulate muscle control. He also receives a high blood pressure medication called Losartan Potassium. Although the evidence relied upon by the Appellant does not speak to those specific drugs, it does paint a picture of a health system, and a country, in crisis. I accept that this evidence - taken on its own - indicates that there are substantial grounds for believing that there is a real risk that the Appellant will be unable to access all of his necessary medication in a regular and consistent fashion.

32. Dr Dhumad states that it is clear from the Appellant's medical records that the risk of relapse is immediate and high if he stops taking his medication. He has seen over 500 patients from Sri Lanka over the years and he knows from his experience with them that they do not receive the same level of care there as they do in the UK. A relapse will result in a severe heightening of symptoms, in particular the hallucinations, paranoid and delusional thinking that are to some degree suppressed by the anti-psychotics. These symptoms are terrifying, and could very quickly lead to the Appellant placing himself in harms way, or directly causing himself harm. I accept on the basis of this evidence, which appears to be unchallenged, that without the Appellant's medications he will suffer a serious and rapid and irreversible deterioration in his mental health.

33. The Savran question then arises: has the Respondent been able to dispel the doubts raised by the evidence adduced by the Appellant?

34. Here we must return to the Country Policy and Information Unit's *Response*. As I have noted, as well as citing generic country background information, this document sets out specific evidence gathered for this appeal, and concerning the drug regime that the Appellant is currently on. The Respondent asked questions of an unnamed medical academic, who is said to have provided the information which appears in the 2020 CPIN. He was asked in particular to comment on the availability of the four drugs that the Appellant's GP currently prescribes. The unnamed consultant says this:

'Yes. All four medications are available for free from the government hospitals in Sri Lanka. One would get all of them from Base Hospitals and above- usually within reach of most patients who attend medical and psychiatry clinics.

'Trihexyphenidyl is known in Sri Lanka as Benzhexol as in the British National Formulary.

'Very occasionally [sic], we go out of stocks with one or more of these drugs, for a short while, say one month. But, usually they are available throughout the year from private sector pharmacies.

'The generic drugs cost very little. For example, Losartan 50 mg tablet at present would cost about SLR 30.00 (thirty rupees) [£0.071] from a private pharmacy. And Sertraline might be around SLR 40.00... [£0.102] per tablet. The other two are very cheap, less than five rupees when buying generics.'

35. Mr Tan asked me to find on the basis of this evidence that the doubts raised by the Appellant have been dispelled. It is clear from this that he would face no difficulties in getting the required medications. Mr Tan further argued that my analysis should not be confined to that matter. I should also consider whether the appropriate care, in the wider sense, would be forthcoming: this requires me to take into account evidence about hospitals and support generally for psychiatric patients. Section 5 of the *Response* explains:

5.1.1 The Asia Pacific Observatory on Health Systems and Policies (APO) report - Sri Lanka health system review, 5 July 2021, noted:

'The mental health sector provides its services through a multidisciplinary team consisting of consultant psychiatrists, MOs [Medical Officers] of mental health, psychologists, counsellors,

occupational therapists, speech therapists, physiotherapists, psychiatric social workers and community workers. Over the past 15 years, there have been major gains in HR [Human Resources] development for mental health across all cadres to support the growing demands on services.

'At the district level, an MO Mental Health is the focal point. The MO assists the Regional Director of Health Services and coordinates all mental health services within the district, having a close linkage with the national level, district health team and all other relevant departments and community groups. Within a district, services are provided through a network of medical institutions and health units... 'There are seven tertiary-care hospitals in Sri Lanka with facilities for acute psychiatric inpatient care. In addition, acute inpatient units are currently available in 23 of the 26 districts and in few regionally managed institutions. Presently, there are 61 adult inpatient units, three child inpatient units and one forensic unit in the country.

'Medium-stay units were available in only five districts in 2004, which has now expanded to 15 districts. Outreach clinics currently exist in almost all MOH [Medical Officer of Health] areas. In addition, community support centres are being set up at district level to serve as hubs for the promotion of mental well-being. 'Outpatient care is provided through specialist, divisional and outreach clinics. Mental outreach clinics provide close-to-home services that enable better care and follow up of clients, and reduce the treatment gap. These clinics support continuity of care, assessment, treatment and home visits. They are conducted by the MO Mental Health or MO Mental Health Focal Point or Consultant Psychiatrist. Home visits are mainly for tracing defaulters and providing assistance to their carers. Home visits are done by a team consisting of an MO, nursing officer and psychiatry social worker.'

5.1.2 The APO report further noted: 'The number of mental health rehabilitation centres in Sri Lanka has grown from one in 2000 to 22 in 2017. These include medium-stay (6 months) and long-stay (1 year-plus) rehabilitation centres. Medium-stay units provide services to individuals who do not require intensive medical interventions but need further treatment and support to develop life competencies to live productively in society. An important part of rehabilitation is occupational therapy that builds life and vocational skills. The rehabilitation centres focus on the client's learning of daily life skills such as self-care, cooking and cleaning. Most of these centres are hospital based and their management may differ from one district to another. In addition to these government rehabilitation centres, NGOs [Non-Governmental Organisations] such as Nest and Sahanaya have their own facilities.'

5.1.3 The World Health Organization (WHO) report - Addressing mental health in Sri Lanka, 6 September 2022, stated:

'By 2022, the expansion of services has resulted in the availability of acute inpatient mental health units in all 26-health districts (Regional Director of Health Service Areas) and intermediate-care stay rehabilitation units provide services in 21 health districts. Similarly, 320 outreach clinics are spread over almost all health divisions... Medium stay units (Rehabilitation centres) are available for intermediate care for a maximum of 6 months. Twenty-one such units are currently operational in the districts.'

5.1.4 The WHO report further added: 'Sri Lanka has worked towards improving mental health services at district level and made sustainable

progress. There is a Directorate of Mental Health, the national focal point, in the Ministry of Health that oversees the National Mental Health Programme. 'At present, mental health services and outreach clinic services are conducted successfully within the districts. Most districts have two or three psychiatrists. Depot injections are given at home by outreach teams to the users who have difficulty in accessing the services due to severity of illness, poverty or other issues. 'Home visits, screening and follow-up of vulnerable persons in need of services are conducted by a multidisciplinary mental health team together with the primary health care team.'

36. Mr Tan submitted that this evidence clearly demonstrates that there have been substantial improvements in mental health provision since GJ. Mr Tan further relied upon the unchallenged finding made by Judge Saffer that the Appellant still has a brother in Sri Lanka to whom he can turn for support. The Appellant would qualify for a resettlement grant of £2000 which would enable him to buy drugs from private pharmacies if necessary. He has made friends here who have supported him, and he has done that whilst he is unwell.
37. Mr Caswell pointed out that he has been given no opportunity to cross-examine the unnamed individual cited in the *Response*. From the description given it has to be assumed that he or she is a teacher rather than an active practitioner. Moreover, Mr Caswell questions how the positive picture painted by this individual can possibly be squared with the information provided in the rest of the *Response*, which is, as set out above, consonant with the information supplied by the Appellant at the time of the First-tier Tribunal hearing.
38. I agree with Mr Caswell that providing information from an unnamed doctor is not terribly helpful. The Tribunal has repeatedly exercised caution in attaching weight to evidence from unnamed sources: see for instance KK and RS (Sur place activities; risk) Sri Lanka CG [2021] UKUT 0130 (IAC), at [302]. I also bear in mind that this is untested evidence. That said, I am satisfied that this is evidence that I can attach some weight to. I do so firstly because the source in question confirms that he has checked his information with a physician. This is important because it indicates that the information is confirmed by someone who is in practice, rather than, as Mr Caswell says, someone who is a full time academic and may not be aware of what is happening 'on the ground'. Secondly because it is evident that the source gives this information against the background of the shortages referred to in the general country background material:
- 'Very occasionally [sic], we go out of stocks with one or more of these drugs, for a short while, say one month. But, usually they are available throughout the year from private sector pharmacies.
39. This specific reference to the shortages suggests that I can be confident that the Appellant's particular prescription will be unaffected. I have to assume that the source who provided this information, and his doctor friend, would not have done so if they believed that those medications are in fact among the number no longer available in the country.
40. Furthermore, and perhaps most importantly, it is evidence which is consistent with the remaining evidence set out in the *Response* about the provision of mental health care more widely. The information in section 5 provides clear evidence that mental health services in Sri Lanka have vastly

improved since GJ was heard. The “major gains” reported by The Asia Pacific Observatory on Health Systems and Policies include the funding of multidisciplinary teams, provision of acute treatment at a local and national level with a total of 61 in-patient facilities, and outpatient care being provided through specialist, divisional and outreach clinics. Mental outreach clinics provide support, continuity of care, assessment, treatment and home visits. In 2022 the World Health Organization reported that the expansion of services meant that most districts have two or three psychiatrists. Depot injections are given at home by outreach teams to the users who have difficulty in accessing the services due to severity of illness, poverty or other issues. That most recent WHO report states that “home visits, screening and follow-up of vulnerable persons in need of services are conducted by a multidisciplinary mental health team together with the primary health care team”.

41. I have considered all of the evidence before me in the round. The Appellant did adduce evidence capable of demonstrating that there were substantial grounds for believing that the healthcare system in Sri Lanka had collapsed to the extent that his needs may not be met. The Respondent has however successfully dispelled the doubts raised by the production of specific evidence going to the particular medicines required by the Appellant. Furthermore the Respondent has produced detailed and recent evidence that Sri Lanka has today a functioning and comprehensive provision for mental health. I am unable to conclude, having regard to that evidence, that there is a real risk that the Appellant will be unable to access the care he requires. His medication is readily available, and there are facilities and support available to him at both national and local level. I have, in my analysis, also given significant weight to the undisturbed finding made by Judge Saffer that he will be supported by family and friends in obtaining the requisite care, and that he will in addition have the benefit of a resettlement grant, which Mr Tan states will be £2000.
42. For those reasons I am not satisfied that the Appellant will be materially deprived of health care on return to Sri Lanka.
43. There remains the question whether the Appellant’s delusional beliefs are such, that even if he has medication, and even if he has access to talking therapies and wider clinical support in Sri Lanka, he would be driven by his illness to take his own life should he be returned there.
44. This must be a serious concern. It is clear from Dr Dhumad’s report that the Appellant continues to experience traumatic and challenging symptoms while he is living in the UK with the support of the NHS and his friends. Following his August 2022 consultation Dr Dhumad made the following observations:

There was evidence of thought disorder (disjointed thinking); he appeared genuinely distressed and distracted and responded to auditory hallucinations. He was slow in responding to questions and was withdrawn.

He appeared severely depressed, anxious, worthless and hopeless, felt unsafe, and was frightened of going back to Sri Lanka. He appeared genuinely scared that he would be killed. He fears persecution if he returns. He feels helpless about his safety in Sri Lanka. He has been actively thinking of ending his life but has not attempted it because of the support of his friends in the UK.

He suffers from paranoid delusions (false unshakable beliefs), he believes the underworld men will kill him, and they follow him everywhere and have scared his friends, and people avoid him because of fear. He has been responding to auditory hallucinations, voices talking about him, distressing and nasty. He has poor concentration and memory difficulties. He believes his thoughts are broadcasted to others, and people know what his thoughts are.

45. It was also the view of Dr Dhumad that the risk of suicide would certainly be increased should the Appellant be returned to Sri Lanka:

He genuinely (and delusional) believes that he would be killed if returned to Sri Lanka. His protective factor is his friends in the UK. Hopelessness, depression, paranoid delusions and hallucinations have a serious and significant association with suicide risk; he has been actively searching for a means to end his life. The risk will be greater when he feels that the deportation is close, and any threat of removal, in my opinion, will trigger a significant deterioration in his mental suffering and subsequently increases the risk of suicide.

46. Dr Dhumad's conclusions have not been challenged by the Respondent, but it is worth noting for the purpose of my decision making that the primary facts in this case do not of course come from Dr Dhumad. It is not he who makes the diagnosis of paranoid schizophrenia. It is the Appellant's GP, and the mental health team at his local hospital. Dr Dhumad's report is nevertheless important for an understanding of how the Appellant is currently coping, and of value for his professional opinion about how that might change should the Appellant be removed.

47. I have attached significant weight to Dr Dhumad's opinion. The difficulty I have in accepting it as a sufficient basis upon which to find the burden of proof discharged is this. Dr Dhumad very specifically premises his analysis on his own belief about two matters: whether the Appellant will have the support of his family, and whether he will be able to access medication. It was his belief that he would have neither. In respect of the former Judge Saffer has though made findings that the Appellant's brother will support him. In respect of the latter, I have accepted that the Appellant will receive appropriate treatment for his illness in Sri Lanka. It is not clear to me from his report whether he believes there to be a real risk that the Appellant would try and kill himself *even if* these protective factors are in place: in other words that the Appellant will be so overwhelmed by his delusional fears/paranoia that there is a real risk of his completing suicide. Without such medical evidence, the burden of proof cannot be discharged.

48. It follows that this appeal must therefore be dismissed on the evidence that is before me.

49. It is clear that further medical evidence must be obtained about the Appellant before he could be removed. I say this because Dr Dhumad assessed him as not fit to fly in August 2022 and without further investigation and certification no commercial airline will carry him. It seems to me that given the severity of the Appellant's illness it would at that stage be appropriate for medical opinion to be sought on the question I pose at paragraph 43 above, given in the context of findings of fact made in this appeal. Should the medical opinion be at that stage that there would be a real risk, then it would be incumbent on the Secretary of State to seek urgent assurance from the Sri Lankan authorities that they have in place the mechanisms to protect and safeguard the Appellant's

wellbeing. I say this because the evidence I have been shown in this appeal does not specifically address that question.

Decisions

50. The decision of the First-tier Tribunal is set aside to the extent identified above.
51. The decision in the appeal is remade as follows: the appeal is dismissed.
52. There is an order for anonymity.

Upper Tribunal Judge Bruce
Immigration and Asylum Chamber
15th December 2023