Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: DA/00607/2012

THE IMMIGRATION ACTS

Heard at Field House
On 27 January 2014

Determination Promulgated
On 13 March 2014

Before

UPPER TRIBUNAL JUDGE KING TD

Between

AISHATU ISHKAU

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Miss A Viswanathan, Legal Representative from Camden Community Law Centre
For the Respondent: Mr N Bramble, Home Office Presenting Officer

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DETERMINATION AND REASONS

1. The appellant is a citizen of Nigeria, born on 25 March 1974. She seeks to appeal against the making of a deportation order against her under Section 32(5) of the UK Borders Act 2007. The decision was dated 23 August 2012.

2. The appeal came before First-tier Tribunal Judge Taylor sitting with Mr P Bompas, non-legal member, on 17 December 2012.

3. The appeal was dismissed on all grounds.

4. Grounds of appeal were submitted against that decision, the focus of which being that the Tribunal failed to pay full account to the medical and mental condition of the appellant, and failed indeed to consider the case law relating to the same as it affected the question of her removal from the jurisdiction. In particular it was argued that there had been a failure to make findings on the risk of suicide which was central to the appellant's Article 3 claim.

5. Permission to appeal was granted.

6. Thus the matter came before Upper Tribunal Peter Lane and Upper Tribunal Judge Taylor in pursuance of that grant of permission on 21 March 2013. It was accepted by the respondent on that occasion that there had been errors of law in the determination of the First-tier Tribunal. In particular it was conceded that the First-tier Tribunal had not engaged with significant aspects of the medical evidence nor with the judgment in **J v Secretary of State for the Home Department [2005] EWCA Civ 629**.

7. Accordingly the First-tier Tribunal determination was set aside for the decision to be remade. Directions were given for the rehearing. It was indicated that a Dr Vermeulen would be giving oral evidence and indeed it was indicated that the respondent was expected to indicate her position in the light of the judicial review and of Dr Vermeulen's report.

8. That review was carried out and there is also within the papers a Supplementary Reasons for Deportation dated 9th November 2013. Essentially it is the position of the respondent that notwithstanding the mental health of the appellant she can be returned to Nigeria and indeed ought to be returned.

9. At the resumed hearing the appellant was represented by Miss Viswanathan and the respondent represented by Mr Bramble, Home Office Presenting Officer. I was presented with a skeleton argument on behalf of the appellant together with a bundle of documentation of some 250 folios. Although there had been a very substantial volume of documents that had been presented before the First-tier

Tribunal, Miss Viswanathan indicated that she was relying to all intents and purposes upon the documents in the new bundle.

10. It was indicated that the appellant was unfit to give evidence and therefore did not attend. Evidence was to be given by Dr Jan Vermeulen

11. The immigration history of the appellant is somewhat complex and I set it out briefly in this determination in an effort to put the evidence into its proper context.

12. The appellant first arrived in the United Kingdom on 22nd September 1999 with a student visa which was successively renewed until 2006. During that time she married a British citizen, Mr Mark David, in 2002.

13. On 15th February 2006 she submitted an extension application for her student visa which was refused. Her appeal rights became exhausted on 20th March 2007.

14. On 13th February 2007 the appellant submitted another student visa application which was refused. A subsequent appeal on that matter was dismissed as was her application for judicial review.

15. On 11th June 2009 the appellant was convicted of three counts of dishonesty, making representations to make gain. She was sentenced to a total of two years' imprisonment. A psychiatric report was prepared in HMP Holloway by Dr Faisil Sethi. It was his opinion that the appellant was suffering from mental disorder.

16. On completion of her sentence on 2nd April 2010 the appellant was detained on immigration powers and was transferred to Yarl's Wood IRC on 2nd June 2010. She was assessed by Dr Andrew Whitehouse, a consultant psychiatrist, during this time. On 1st July 2010 the appellant's appeal against her deportation order was dismissed and her appeal against that decision also dismissed by the Upper Tribunal.

17. Following the instances of self-harm and expressed suicidal thoughts the appellant was reviewed by a Dr Balakrishna in September 2010. Seemingly her mental health had deteriorated whilst in detention and the appellant made attempts to harm herself in detention.

18. The appellant then made an asylum claim and was interviewed in connection with that matter on 7th December 2010. Dr Koton, a consultant psychiatrist, assessed the appellant in December 2010 and found that she had obsessive compulsive features of extreme severity.

19. The appellant's asylum claim was refused and certified in a letter dated 17 February 2011. On 16th March 2011 the appellant was informed that she would be interviewed by the Nigerian High Commission for the purposes of redocumentation. She attempted suicide. Consequent to the suicide attempt and application was made to revoke the deportation order on the basis that there was a real risk of suicide which

would lead to a breach of her rights under Articles 3 and 8 of the ECHR. The respondent rejected those further submissions.

20. In June 2011 the appellant was assessed at Yarl's Wood by another psychiatrist, a Dr Karnath. He found there to be an ongoing chronic illness quite likely to be a schizophrenic disorder into OCD. She had beliefs of paranoia and chronic beliefs of delusional intensity. Thereafter the appellant was seen by Dr Sagovsky and Dr Samuels.

21. On 19 October 2011 the deportation order was revoked and the appellant was transferred to Cygnet Hospital. She remained, however, detained pursuant to Section 32(5) of the UK Borders Act 2007. At Cygnet Hospital the appellant was transferred to Bedford Hospital as a voluntary patient and then transferred back to Yarl's Wood. She was released from immigration detention on 14 November 2011 to Barry House where she underwent a community care assessment by the South London and Maudsley Mental Health Team. She has been supported by Southwark County Council under the National Assistance Act since December 2011.

22. The appellant was notified by the respondent that she is liable to automatic deportation under Section 32(5) of the UK Borders Act and it is this immigration decision which is the subject of the current appeal.

23. The issues which are highlighted for consideration in this appeal are essentially two fold. The first issue relates to asylum it being contended that the appellant as a mentally ill person falls within "social group" as defined in the leading case of **Forna.** It is said that the objective evidence is supportive for the proposition that were she to be returned to Nigeria she would be exposed to the risk of ill-treatment because of the cultural approach to those who have mental illness and who may be considered to be possessed by spirits.

24. The second issue relates to Article 3 of the ECHR it being contended that the appellant's mental condition precludes any safe return and even if returned would suffer suicide or degradation. Linked with that but clearly subsidiary to it is the suggestion that Article 8 is engaged in any event.

25. Dr Jan Vermeulen gave evidence, speaking essentially to his various reports of 12 March 2013, 14 March 2013, 27 September 2013 and 21 January 2014. He is a consultant in general adult and forensic psychiatry.

26. He has seen the appellant on a number of occasions both in detention and in her flat.

27. His report of 12 March 2013 is the basic document to which he makes reference. It is of considerable length. It is perhaps unnecessary to set out in great detail that report. It highlights a number of visits and also incorporates comments made by other psychiatrists who have seen the appellant. It seeks to be a chronological history of her mental condition.

28. It was his understanding from speaking to the appellant that she went to Nigeria in 1997/1998 and was involved in a traumatic bus accident in which some 30 people died. It was the view of the witness that the appellant had been suffering from mental disorder and particularly OCD for a long time as a child. To what extent the bus event had worsened the effect of the obsessive compulsive condition of the appellant was far from clear. It was noted that some eighteen months after the event in February 1999 the appellant attempted suicide and was admitted to the Emanuel Mental Hospital found to be suffering from mental disorder. The OCD was a chronic condition that fluctuates depending on the nature of treatment that is given. In his view the appellant would need some two years of sustained therapy and follow up procedures in order to stabilise her condition . Although he made such a recommendation in his report of 12 March 2012, nothing seems to have been done to facilitate that treatment because of her anxiety or uncertainty as to her status in the United Kingdom. It is clear that the appellant does not wish to be detained in a hospital and would respond adversely to any compulsory medical treatment order that might be made. He is however of the view that the appellant would, with community support and an organised programme, respond well to that. He speaks of the need for outpatient treatment and group therapy.

29. Dr Vermeulen relies particularly upon his most recent visit to the appellant as set out in his addendum report of 21st January 2014. He interviewed the appellant for 30 minutes at her residence on 17th January 2014. He has previously seen her on 8th February 2013, 15th February 2013, and 31 August 2013. The new flat was cleaner than the previous flat but was dark and uncomfortably warm. The appellant was agitated and speaking rapidly and incoherently. He said that a constant feature of the appellant's mental health was that she was obsessed with being possessed by some 60 spirits. Her compulsive behaviour manifested itself in different ways over the period that he had known her and was a way to try to exorcise those spirits. The appellant thought that meeting other people would mean they too passed her their spirits. On some occasions she has showered 60 times a day, on others ten times and others none at all. she has however her process of behaviour designed to control or exorcise such spirit. He describes her on the latest visit as wearing the same pink track suit she was wearing on previous occasions. She was also wearing transparent gloves and overshoes.

30. It was his opinion that there had been a significant deterioration in her mental state since 31 August 2013. She has lost insight and held her beliefs with delusional intensity. Her speech was difficult to follow and she was experiencing auditory and tactile hallucinations and experiencing delusional persecution. She required the appropriate treatment for her condition.

31. She had attempted suicide in the past, particularly when in detention and had cut herself in the past. Without treatment he considered that her chances of accidentally killing herself was very high unless closely supervised.

32. He was asked to comment upon the risk to the appellant were she to be detained with a view to removal. He highlighted that the incidents of attempted suicide and self-harm often coincided with periods of detention or compulsory treatment in hospital. The appellant did not want to go to hospital because she felt that she would be detained.

33. It was his view that she would require some form of restraint to prevent her self-harming which may mean medication. That medication suppressing respiration may in itself be a risk factor. There would need to be a careful balance between medication to calm the appellant down and restraint to prevent her harming herself. It is his view that that would be a difficult combination in the circumstances of the appellant although not impossible.

34. He was asked about what would happen to the appellant in all probability were she to be returned to Nigeria. He said that he used to be a member of the African Psychiatric Association particularly involved with doctors from Zimbabwe. There was considerable talent in Nigeria and there would be very competent doctors in Nigeria to treat the mental problems of the appellant.

35. The central issue was whether or not she would be able access the level of treatment that she required to prevent self-harm and suicide. He said that the level of treatment for OCD was generally lower in Nigeria simply because of less availability of treatment.

36. He indicated that he had interviewed the appellant for considerable periods of time over a fairly lengthy period, some ten hours in total. He said that he was able to make a proper assessment as to her mental condition. He said that the subsequent history was consistent with her having experienced the trauma of the bus accident although that had not been independently verified as having taken place. Generally he assumes that patients are telling him the truth.

37. As to the suicide attempt in 1999, Dr Vermeulen agreed that that came from the account of the appellant herself. In that connection his attention was drawn to the report prepared by Andrew Whitehouse arising from his visit to the appellant in Yarl's Wood on 16th July 2009 and 29th July 2009. In that report it was noted that although the appellant had suffered in the past with panic attacks she had never tried to harm herself or tried to harm others. He repeated that he could only rely upon that evidence which was given to him by the appellant.

38. Dr Vermeulen was referred to his report and to the events in June 2011. These were notes based upon the accounts of other doctors who had visited the appellant, particularly when she had been taken into custody in Yarl's Wood. She was depressed and self-harming and said to have suicidal ideation. She needed treatment but was refusing it. In August of that year she was noticed biting and chewing her arm and claimed to have swallowed a sharp nail in October 2011 and went to hospital for investigation. A possible suicide attempt was noted in the incident

report of 16 March 2011 where a ligature would seem to have been tied around her neck in the bathroom. The point is made in the report of Professor Koton of 15th December 2010 which referred to cutting and her wish to throw herself down the staircase. It noted that whilst in Yarl's Wood her behaviour was becoming increasingly unmanageable. Dr Vermeulen agreed that according to his detailed notes that was the last incident of attempted suicide and that the last occasion of self-harm was in Barry House in 2011.

39. Dr Vermeulen indicated that her anxiety would increase with any attempts to detain or remove her and she would require constant monitoring to protect her from herself and self-harm. He indicated that with treatment and particularly cognitive therapy the appellant has always responded well and her condition has improved. He sees no reason why with the proper cognitive treatment the appellant's condition could not improve. Conversely however any attempt to remove her would aggravate her situation.

40. He repeated that her condition would seem to have deteriorated. When she had gone out to buy groceries on one occasion she was mugged and so had not left the flat since 2012. When he had seen her in March she had lived in a flat in dirty conditions, she fearing to shower. On the last occasion she was clean, she having been able to shower, indeed showers ten times a day. Nevertheless she continues with her obsessive thoughts, particularly of the evil spirits and her fear of using the toilet itself.

41 He spoke of the fluctuation in her chronic condition. It would always be there but could be controlled and indeed there would be times when she could be well enough to organise her own events. Cognitive behaviour therapy would assist her in managing her moods and controlling her obsessive thoughts and delusions. It was the anxieties that she had with her spirits and with the ongoing court process that has contributed to her condition. He agreed with Mr Bramble that she could be removed but that would require careful management. There is no reason at all why, with support, she could not access proper medical treatment in Nigeria, the difficulty being whether she would be able to manage herself in that context. He agreed that her behaviour was very odd and had always been very odd particularly the ways in which she dressed and expressed herself.

42. The parties made their submissions to me.

43. In terms of asylum, Miss Viswanathan makes it clear that the basis for the current claim of the appellant's mental condition being of a permanent nature such that she falls to be considered as a member of a social group within the authority of **SSHD v Gay and Fornah** **[2009] UKHL 46**. Essentially it is submitted that by reason of her mental condition she will be viewed as an outcast and ill-treated accordingly. Reliance is placed upon the report of Mario Aguiller of 28th November 2012 together with other country documents. It was acknowledged that at the hearing before the First-tier Tribunal asylum was also raised on the grounds of the appellant's sexuality.

That is not however to be proceeded with, particularly as it was certified under Section 72.

44. Mr Bramble invites me to be slow to find credibility in what the appellant herself has to say about her experiences in the United Kingdom or in Nigeria. He invites my attention to her immigration history. He submits that I should be slow to accept any credibility of the appellant unless verified by other independent evidence. He invites me to place little weight upon the expert country report and submits that the issue of witchcraft and evil spirits is not one that arises in any practical sense because the appellant will have a family support or network to return to. He asks me to consider that as part of the offending behaviour the appellant had sent some £31,000 to a bank account in Nigeria. He invites me to find that is evidence that the appellant has maintained connections in Nigeria.

45. On the second issue of Articles 2 and 3 Miss Viswanathan invites me to find that, given the mental history of the appellant and indeed its deterioration over recent years, there would be a high risk of suicide within the process of removal let alone upon removal. She invites me to find that argument advanced on behalf of the respondent that the appellant has family simply because she has funds in a Nigerian bank account that is speculative in the extreme. She invites me to find that without family support the appellant will be unable to manage her condition and lacks insight into it such that her condition will further deteriorate, leading to suicide and self-harm.

46. The starting point for the order for deportation lies clearly with the nature of the appellant's offending. It is unnecessary to analyse in great detail the public interest in removal as that is clearly assumed and marked by the legislature in the statutory framework.

47. The offences for which the appellant was sentenced to two years' imprisonment at the Crown Court on 13 August 2009 were three counts of dishonesty and false representation. In the sentencing remarks, the judge stated that the appellant was not authorised by the Financial Services Authority and was very well aware that what she was doing was thoroughly dishonest. It was found that the appellant had transferred £31,000 abroad and that there were passports in her flat belonging to other people. She was involved in a complex and sophisticated series of frauds causing substantial loss in respect of each victim.

48. In his sentencing remarks the judge considered that the appellant was manipulative and persuasive and was using false documents knowingly. The first count was a fraud of £9,700 on the University of Westminster with the use of fraudulent documents to deceive the university finance department on financial matters. The second count involved the appellant's false claim that she had set up an investment scheme and persuading a victim to invest £9,375 in the same. The third count involved a property letting company causing a loss to the company of £20,000. The appellant had intended to sub-rent the flats which she had falsely obtained from the

letting company. She had been arrested and bailed but following her absconding she was rearrested. The judge found the appellant to be an intelligent person and considered that the appellant probably had obsessive compulsory disorder but that played little part in the offences.

49. It is to be noted that prior to her offending behaviour the appellant was a student, having obtained a degree in the course of her studies.

50. The earliest medical report which seems to be relied upon is that of Dr Johannes Mousa dated 19th July 1999 from the hospital in Addis Ababa in Ethiopia. According to the author of the report he was asked by the mother of the appellant to conduct a psychiatric examination of her daughter. Reference is made in that report to the fact that in February 1989 she had been taken to hospital after an attempt to commit suicide using a rope in her mother's home. Reference is made to the event in 1998 involving the accident with the vehicle in which people were killed. Reliance is placed upon that so-called first suicide attempt but has been indicated when the appellant was seen by Dr Whitehouse he makes no mention of that previous attempt.

51. The recommendation of Dr Mousa was that the appellant showed variations in her temperament and should be in a mental institution for the rest of her life as she was affected not just by a single disorder of schizophrenia, diverse gender personality but self-harm and compulsive suicidal influences. Notwithstanding that rather dramatic conclusion the appellant was not detained in a mental institution and for many years thereafter managed to live a relatively normal life as a student and as an individual both in Ethiopia and in the United Kingdom. Significantly for her offending, she knew what she was doing and was manipulative and sophisticated in that which she undertook.

52. Thus there have been long periods in the life of the appellant where she has lived her own life and monitored her own affairs and monitored her behaviour.

53. It is significant that the majority of the many psychiatric reports that have been prepared upon the appellant postdate her offending and detention, with no offending and arise whilst she is in detention.

54. I do not set out in detail the report of Dr Vermeulen who in effect summarises the various reports that have been prepared on behalf of the appellant. There is for example a visit recorded in May 2010 in which the comment is made that the appellant is very articulate and able to communicate well. She is not presenting with any psychotic features despite hearing and seeing spirits. A month later there is an entry that she is very uncooperative and expresses suicidal thoughts. In June 2010 she declines medication or counselling. In July there are two occasions of attempted self-harm at HMP Bromsfield. In August medication is discussed and a care plan developed. In September 2010 there are reports that she attempted to drop herself from the top of the stairs and tried to tie her neck with a mobile phone charger cord. She was tearful and stated that somebody had upset her. In March

2011 when she was due to go Colnbrook for her immigration interview she was found on the floor of the bathroom with a ligature around her neck. Thereafter there are a few incidents of self-harm. Dr Kanath believes that her detention is detrimental to her mental health. Thereafter follows several more incidents of self-harm.

55. Most of those who have observed the appellant comment that although she suffers from obsessive compulsive disorder she would benefit from the care of a consultant psychiatrist and mental health team. When she was seen on 17 November 2011 she had deteriorated to such an extent in custody that Dr Kanath considered that she should be admitted to hospital. She was sent to Barry House where she seemed to self-harm. She was thereafter admitted to the Jim Birley Unit in October 2012 as an informal patient. A Mental Heath Assessment took place on 5 October 2012. She agreed to remain voluntarily on the ward and continued to improve and was discharged on 18 October 2012. It was noted shortly before discharge that the appellant appeared well presented with no evidence of self neglect.

56. Without attempting a detailed analysis of all the medical reports, it seems to be common ground and I so find that the appellant's condition is chronic in that it will never be removed from her personality but varies as to its nature and effect. Part of the process of stabilisation is to enable the appellant to have access to the appropriate medication, to the support of the mental health team and in particular to the therapy. It is the view of Dr Vermeulen as I have indicated that she responds well to such matters. The difficulty present is that her condition has deteriorated simply because none of these facilities have been made open to her given the uncertainty of her status and position.

57. It seems to me that that is an important consideration in the overall context of this particular case. The appellant is not somebody who lacks insight into her condition or the ability to run her own life and affairs. She has demonstrated both as a student and by her criminal conduct that she can organise herself and plan a clear and coherent outline for her living. She has managed her life with society albeit with the underling medical and mental conditions which she has. She is not somebody therefore that has lost permanent insight into her condition or has demonstrated that she is incapable of managing her own affairs. Rather it is clear, I so find, that she knows very much her own mind and that her moods vary very much according to whether she feels under pressure or under threat.

58. It may well be therefore that were the appellant to have access in Nigeria to proper medication and support her condition would be such that she could manage her own affairs.

59. To some extent that may well depend upon what family or community support she would be able to call upon and/or what support she could obtain through her financial security having some £31,000 in a Nigerian bank and also some £40,000 by way of compensation from the government for her detention.

60. The burden of the claim for asylum is not so much the appellant's ability to manage her health but rather the perception that society would have of her as a mentally disturbed individual. Reliance is therefore placed heavily upon the report of Mario Aguiller dated 28 November 2012. Professor Aguiller sets out his qualifications, in particular his academic qualifications in socio-anthropology. It is far from clear from his report what direct experience he has of life in Nigeria. He makes reference to the World Health Organisation's Report on Nigeria and various medical studies conducted and set out on a website or internet. To what extent his report is from his direct experience and how much is from research is far from clear.

61. In his report he states that it is clear from the objective data that Nigeria struggles to provide basic medical treatment to its citizens and is struggling to contain major illnesses such as diabetes, TB and HIV. The national health system of Nigeria does not have adequate provisions for mental health treatment or prevention of suicide or long term treatment of the seriously mentally ill. Despite that somewhat sweeping statement Professor Aguiller does not give any source material for those contentions. It somewhat conflicts with the evidence of Dr Vermeulen who speaks of a considerable degree of expertise within the country of Nigeria.

62. According to Professor Aguiller signs of mental illness are culturally associated with witchcraft and evil spirits and thus Nigerians would avoid or reject with violence people with serious mental illness in public. Once again that is a sweeping comment ,that seems to be little reference to source material. No distinction seems to be made between the city conurbations and the rural village areas. The report deals at length with the concept of witchcraft and evil spirits in a more general way.

63. He comments at paragraph 20 of his report that people in Nigeria need to have money in order to pay for medication. He says that the appellant will have no access to medication if she cannot pay for it and will have no ability of long term care or any scheme that would prevent her intended suicide. Once again that is a sweeping statement without any particular foundation or support for it. In this case, of course, the reverse is true. Far from being impecunious the appellant has a very substantial fund available to her both to purchase medication and also no doubt to purchase care facilities if need be.

64. I place little weight upon the evidence of Professor Aguiller because of the lack of balance, as I observe it, and for the unsourced nature of the statements. Nigeria is an extremely large country, diverse both into its culture and into its religions. The report seems to make no acknowledgment of that fact nor seek to be more particular in its terms.

65. Mr Bramble by contrast invites my attention to the COIS Nigerian Country Report dated June 2013, an extract which has been produced in support of the references made to it in the Supplementary Reasons For Deportation set out on 9 November 2013. Reference is made to the inadequacy of the health care delivery system as attributed out the particular democratics of the population. 45% of the population

live in urban areas and 55% live in rural areas only. It is said that 70% of the health care is provided by private vendors and only 30% by the government. It speaks of the fact that over half of the population live below the poverty line on less than $1 per day and cannot afford the high cost of health care.

66. There are however three levels of health care. There are teaching hospitals and specialist hospitals and the federal government works with voluntary and non-governmental organisations as well as practitioners. The statistics show that health institutions rendering health care in Nigeria are over 33,000 general hospitals, 20,000 primary health centres and posts and 59 teaching hospitals. That represents a huge improvement over the last few decades although there is still a shortage.

67. In private hospitals some have adequate equipment and others not. They are accessible to anyone who can afford their services. Drugs also are available but may be expensive. The private hospitals in Nigeria provide a higher standard of medical care than public sector hospitals. The report speaks about the providers of medicine and of the various treatments that are available.

68. As to mental health, it is noted that an officially approved mental health policy exists. I areas of Nigeria there is a limited availability of mental health services but available services are often under utilised because of widespread ignorance and supernatural beliefs about the origin of mental illness. Care is provided at the very large mental health hospitals in big cities. Nigeria's mental health facilities consist of eight federally funded psychiatric hospitals and six state owned mental hospitals.

69. Although that report makes it clear that there is much to do in terms of mental heath it does not seek to paint the more negative picture as painted by Professor Aguiller in his report.

70. Miss Viswanthan in her skeleton argument cites the COI report dated January 2012 indicating that studies have found that only 10% of those with severe mental illnesses like schizophrenia received treatment. The majority of the expensive care is paid by parents and families. The submission as advanced in the skeleton argument in that the appellant would require long term treatment and have to fund it and that she has no access to funds because she is incapable of working to support herself and has no family. Quite the contrary, I find that the appellant has very substantial funds to which she may have access.

71. The only direct evidence as to family members or support in Nigeria comes from the appellant's screening interview of 7 December 2010. In it she indicates that her mother is deceased and her father is in Bauchi State. Four stepsisters are named. It is said that they are in the United Kingdom as is one stepbrother. According to the appellant she has little to do with them and does not know their whereabouts. Mr Bramble invites me to find that because the appellant transferred £31,000 to an account in Nigeria that indicates that she has family there. Miss Viswanathan submits that is but speculation. There is no reason at all why the money could not

have been put into her account in order to be used for further fraudulent activities. In any event there was no evidence about that bank account or of the money other than that it was originally transferred. She submits that in returning the appellant of a venerable mental situation, it is quite inappropriate to speculate on family members. I find that there is merit in that submission. However with the finances available to the appellant I find that she would be well able to access the support that she requires. It is clear and I so find that with treatment she will be able to both recognise her own condition and to access appropriate treatment.

72. That having been said, it is entirely apparent that at present the appellant has little insight into her condition and requires external support in order to cope outside the narrow confines of her room. It would either involve obtaining suitable treatment in the United Kingdom or identifying with some particularity where that treatment can be accessed in Nigeria.

73. As to the issue of stigmatisation, I bear in mind also the documents relied upon by the appellant in the bundle particularly those at pages 187 to 204 thereof.

74. I bear in mind the community study knowledge of and attitude to mental illness in Nigeria which seems to be a survey largely conducted in south western Nigeria with some 240,000 persons participating in the survey on stigma. How far they are representative of that area in particular or of Nigeria as a whole is perhaps less clear. The report perhaps reveals a wide ignorance as to mental illness indicating that most of those spoken to were unwilling to have social interaction with some with mental illness being perhaps a more liberal attitude in urban areas. Such report is not supportive of the suggestion that is implicit within the asylum claim that the appellant would be exposed to open hostility or violence. That she might find it difficult to establish social contact with people is of course a relevant factor in considering the reasonableness of return but equally it is to be recognised that a lack of social contact is her experience in the United Kingdom and indeed is an unfortunate consequence of her illness. She is reclusive in the United Kingdom and it does not necessary follow that being reclusive in Nigeria would necessarily be otherwise than an outward expression of her inward illness and not as such therefore undermining of her fundamental human rights. The example of the medicine man is particularly unhelpful as it is by no means a requirement that the appellant visit such a person. In effect much comes to the issue of what support mechanism would be available to the appellant were to return.

75. I turn to consider perhaps the wider issue that of the appellant's general mental health and of the risk and likelihood of suicide upon transportation to Nigeria and return thereto. In that connection I bear in mind the decision of **J v SSHD [2005] EWCA Civ 629**.

76. The structure for considering foreign cases is set out in paragraphs 25 to 32 of the judgment. I recognise in particular that in the context of a forgiven case the Article 3 threshold is particularly high.

77. In considering the appellant's current mental health and the current risk of suicide or of self-harm it is significant to note that the last incident complained of was that in custody in 2011. Much is made of the previous incident the subject of Dr Musa's report as establishing a higher category of suicide risk so far as the appellant is concerned. That was, however, a date very far into the early life of the appellant.

78. I bear in mind the evidence of the various doctors that have seen the appellant and particularly that of Dr Vermeulen who has seen her perhaps more consistently out of a detention context. His view is that she requires treatment which she is not having and that certainly in the last few visits her delusional thoughts are very strongly expressed. Notwithstanding however the lack of treatment, which in his view is required in order to stabilise or assist the condition, there is no suggestion that she has self-harmed or sought to commit suicide. Thus although it may well be right to note that without treatment that risk increases in practical terms, there has been no such attempt since 2011 albeit that her condition has significantly deteriorated since then. I find therefore that in general terms the suicide risk, even for a condition which is untreated, is in practical terms a low one notwithstanding the comments made by the various medical reports.

79. I find therefore that a general risk of suicide is not objectively well-founded .

80. However, as is required in the case of **J**, I must consider whether the removing and/or receiving state has effective mechanisms to reduce the risk of suicide. It is apparent from the reports that when in detention or custody the risk of suicide is much greater as is also the risk of self-harm. A number of examples were given at or around 2011 to substantiate that risk. I find, therefore, that it is reasonably likely that were the appellant to be taken into custody with a view to removal her suicide risk would significantly increase. As Dr Vermeulen recognised, there would therefore need to be a balance between restraint and medication. He does not view that as being impractical but advises care in the balance that has to be adopted. Those seeking to restrain the appellant will of course need to be very much on the alert for the incidents of self-harm and/or attempted suicide. Those risks were managed and monitored on previous occasions and I find that the removing state would have effective mechanisms to reduce the risk of suicide and self-harm.

81. I have, therefore, to consider what would be the suicide risk were the appellant to arrive in Nigeria. It seems to me that the nature of the risk is a function upon what support is available to the appellant either through family and friends or though an agency or hospital. As I have indicated before, isolation from the community may not be as significant a feature, particularly as that isolation is already present in her life in the United Kingdom. I do not find that it would be necessary for her to be restrained in hospital or closely monitored. It does not happen in the United Kingdom and, as I have indicated, there is no suggestion that suicide is the likely consequence from that. Clearly, however, were she to deteriorate further into delusion then such risk on all the medical evidence could not be excluded. As Dr

Vermeulen has indicated, cognitive therapy would be of great assistance to the appellant both in terms of recognising her behaviour and doing something certainly to modify it or to handle her condition. At present it would seem that she had very little insight into her own delusions. There therefore needs to be some support in place upon her arrival in Nigeria for the appellant to access reasonable treatment or assistance in monitoring her condition.

82. As was made clear by the respondent in the Supplementary Reasons for Deportation of 9 November 2013, on her deportation to Nigeria she would be escorted by a doctor and appropriate medical escorts and in Nigeria she could continue her residence with the appropriate medical treatment. I have noted that the appellant has family who remained in Nigeria, namely her father, four stepsisters and one stepbrother . Whether or not they would be in a position to assist or willing to assist cannot be determined with accuracy at this time. Nevertheless it is clear, and I so find from the objective material provided, that suitable treatment for the appellant is available in Nigeria and that she would have access to that treatment given her significant financial means.

83. I recognise in fairness to the appellant, however, that given her current situation of delusion and bizarre behaviour, it is far from clear as to whether or not she would have a sufficient cognitive grasp of reality to effectively manage those finances. Nevertheless were her condition to be stabilised I see no difficulty in her managing her financial affairs. The significance of her offending behaviour in 2009 is indicative of a high degree of financial management skills that she was able to employ in establishing her affairs albeit in a dishonest way. '

84. Applying therefore such findings as the issues as originally raised in the course of the appeal, I turn firstly to that of asylum. Even were it to be accepted that as a mentally ill person the appellant could fall within a particular social group I do not find, for the reasons that I have already set out ,that she would face a real of injury or violence or depravity were she to be returned to Nigeria. Even were there to be some degree of social avoidance such is her experience generally in her lifestyle in the United Kingdom. Although her behaviour may remain somewhat odd, proper treatment would better enable her to meet people and have some normality of life. I do not find that the societal attitude towards witchcraft and of evil spirits would be such as to manifest itself in persecutory conduct towards the appellant as envisaged either within the Geneva Convention 1951 or in the Immigration Rules. She would have the support of family or of a caring agency whose services she could pay for. Her odd behaviour may lead to people avoiding her but I find little evidence to support the proposition that they would attack her or ill treat her.

85. So far as Articles 2 and 3 are concerned, I bear in mind the jurisprudence set out not only in **J** but also in **GS and EO (Article 3 – health cases) India [2012] UKUT 397**. I do not find that evidence establishes any such aggravation of mental suffering of the intensity as seen in **Soering** were the appellant to be returned. I find that she would have proper access to suitable medical treatment. If, however, the appellant were to

be returned in her current situation, it would be incumbent upon those seeking to return her to establish that the mechanism of proper support appropriate to her needs would be available upon arrival in Nigeria.

86. Aside from the issue of suicide risk, I also consider the proportionality overall as to the return of the appellant bearing in mind her fundamental human rights.

87. In all the circumstances I find that the overriding balance is to preserve the public interest bearing in mind **SS (Nigeria) [2013] EWCA Civ 550** and the need to express society's disapproval of the sort of offending behaviour as demonstrated by the appellant. Although the overall risk to her reoffending has been stated as being low, I find that overall her removal is proportionate to the public interest in this case.

88. I bear in mind also paragraphs 398, 399(b), 399A, noting in particular that if paragraph 398(c) does not succeed it would only be in exceptional circumstances that the public interest will be outweighed. I bear in mind **MF (Nigeria)** also in that context.

89. I do not find there to be any such exceptional circumstances in this case. Her private life is very much confined by her illness and there are no wider family or social connections relied upon. The nature of her relationship with her husband was considered by the Tribunal on a previous occasion and it is not a matter relied on in this appeal I do not find that the appellant will face persecution for a Convention reason upon return. I find that with proper medical assistance her mental condition can be stabilised and/or improved such that she is not of harm to herself or to others. She can regain a significant element of her private life in Nigeria. I do not find any significant reduction in the quality of life that she would enjoy in UK with treatment and that in Nigeria. I find that it is proportionate to remove the appellant, subject of course to the safeguards as to the process of removal and the obtaining of support in Nigeria.

90. In all the circumstances therefore the appeal in respect of the immigration decision is dismissed. That in respect of asylum is dismissed. That in respect of Articles 2, 3 and 8 is also dismissed.

Signed Date

Upper Tribunal Judge King TD