Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: PA/11930/2016**

THE IMMIGRATION ACTS

Heard at Bradford IAC as a remote hearing
On 9 June 2021

Decision & Reasons Promulgated
On 30 July 2021

Before

UPPER TRIBUNAL JUDGE REEDS

Between

MO
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Mr Hussain, Counsel instructed on behalf of the Appellant
For the Respondent: Mr Diwnycz, Senior Presenting Officer

DECISION AND REASONS

1. The Appellant is a citizen of Afghanistan.

2. Anonymity

Rule 14: The Tribunal Procedure (Upper Tribunal) Rules 2008

Anonymity was granted at an earlier stage of the proceedings because the case involves protection issues. I find that it is appropriate to continue the order. Unless and until a tribunal or court directs otherwise, the appellant is granted anonymity.

No report of these proceedings shall directly or indirectly identify him. This direction applies both to the appellant and to the respondent. Failure to comply with this direction could lead to contempt of court proceedings.

The background:

3. On 25 June 2010, the appellant claimed that he had entered the UK clandestinely by lorry and he claimed asylum. He was an unaccompanied minor at th time of his entry to the UK. The basis of the appellant's claim is that he lived in Kunduz with his parents and his siblings. He claimed that his older brother A worked as a driver for a foreign company in Baghlan. His brother began to receive threats from the Taleban for working for a foreign company and he disappeared in 2008. The appellant then started to receive anonymous telephone calls mentioning his brother. In fear for his safety's the appellant's father arranged him to live with a family in Pakistan. His father was then approached by an intermediary for the Taleban stating they wanted to know the appellant's whereabouts. The family home was attacked, and his father concluded Pakistan was not safe enough and made arrangements him to travel with agents to Europe.

4. The application was refused on the 25 June 2010, but he was granted discretionary leave until 31 August 2011 on the basis that the appellant was a minor.

5. On 30 August 2011, the appellant applied for further leave to remain. This was refused in a decision made on 7 February 2012. He appealed the decision, and it came before the FtT (Judge Mark-Bell) on 23 April 2012.

6. In a decision promulgated on 2 May 2012 the FtTJ made the following findings:

   (1) the appellant had not given a credible account [21]

   (2) the judge rejected his claim that his brother had become a target of the Taliban and also rejected his claim that the Taleban had turned their attention to the appellant because his brother had evaded them (at [26]).

   (3) The judge did not find it credible that if the Taleban had thrown a grenade into the family home, that everyone would be unscathed, and that the family would continue to choose to remain to live there (at [27]).

   (4) The judge did not accept the appellant's claim that he was related to the governor of his home province (at [28]).

   (5) In the alternative, he was satisfied that the appellant could safely relocate to Kabul (at [29]).

7. The FtTJ therefore dismissed his appeal.

8. The appellant sought permission to appeal the decision and permission was granted by FtTJ McWilliam on 28 May 2012. The appeal came before the Upper Tribunal (panel) on 24 April 2013. The Upper Tribunal rejected the appeal grounds that had been advanced before the tribunal which consisted of the failure to consider the evidence and in the light of the documentary evidence provided. The panel found that the challenge and submissions "essentially amounted to a disagreement with the

findings of fact and the conclusions". Therefore the tribunal upheld the negative credibility findings made by the judge but found error in relation to the removal direction.

9. On 4 October 2016 the appellant submitted a fresh claim for asylum. The basis for his claim is that he was at risk on return as he had been threatened by the holy warriors of the Islamic Emirates. He also disagreed with the findings of the earlier judge. In support of his claim he provided a letter dated 25 February 2013 with translation. The appellant further claimed that he would be unable to return to Afghanistan as a result of the general insecurity in that country. Further submissions were made on article 8 grounds relating to his relationship with his cousin with whom he had resided since his arrival as an unaccompanied minor.

10. In a decision made by the respondent on 12 October 2006 in his claim was refused.

11. The appellant appealed the decision, and it came before the FtT (Judge Buchanan) on 29 November 2017.

12. In a decision promulgated on 9 February 2018 the FtTJ made the following findings:

    (1) The FtTJ applied the decision of Devaseelan to the earlier findings of Judge Mark Bell.

    (2) When considering the new evidence described as a "notice" the FtTJ did not accept this to be a reliable document; he rejected the evidence of his cousin as to how he had come across the document in Afghanistan the document was a poor photocopy and easily manufactured and the appellant was not clearly named in the translation. Therefore he attached no weight to the notice (at [39]).

    (3) As to the appellant's assertion that he lost all contact with his family, the FtTJ observed that "beyond a bald assertion to this effect from the appellant and from (his cousin), no further evidence was provided. He stated "the family of the appellant is large and the family of RR and that of RR's wife lived in the same village. No evidence was provided as to when and in what circumstances the family of the appellant had left the village as was asserted and the lack of evidence on this matter was a concern. The judge found that the appellant had not established the required standard that he lost contact with his family in Afghanistan (at [40]).

    (4) As to his family circumstances in the UK, the FtTJ set out that he had rejected the evidence of RR in respect of the notice but accepted that RR was his cousin and that the appellant had lived with him and his family since 2010 (at [41]).

    (5) The FtTJ concluded that there was no evidence to go behind the factual findings made by Judge Mark Bell. The judge concluded that the appellant would not be at any particular or specific risk on return to Afghanistan.

    (6) As to his medical claim, it was noted that the appellant was taking daily antidepressant medication but that it could not meet the high threshold for a breach of article 3.

(7) Nor could the appellant demonstrate that there was a level of indiscriminate violence in Afghanistan which would fall within Article 15(c).

13. His claim was dismissed for a second time. He sought permission to appeal that decision on the basis that the judge failed to consider the evidence in the context of the background situation in his home area of Kunduz and erred in failing to consider his mental health when assessing whether it would be unduly harsh for him to relocate to Kabul. Permission was granted on 14 March 2018.

14. The appeal came before the Upper Tribunal (Deputy UTJ Doyle) on 10 August 2018. The Deputy UTJ remitted the appeal to the FtT in the light of the CG decision of AS (safety of Kabul) Afghanistan CG [2018] UKUT 00118, which had not been before the FtTJ, and in the light of the medical evidence related to his mental health, the judge was in error by not considering the effect of the appellant's mental health on the viability of internal relocation.

15. The appeal was listed for a third time before the FtT on 12 July 2019 (FtTJ Farrelly). Judge Farrelly set out the earlier appeals at paragraphs [6] – [18]. Whilst the judge made reference to this appeal being a "complete rehearing", it was conceded at the outset of the hearing that the appellant's Counsel was not seeking to reargue against any of the previous negative credibility findings. In particular, the claim concerning threats by the Taleban was not pursued. The judge recorded the nature of the appeal is being "focused upon the appellant's ability to return to Kunduz or alternatively, to relocate to Kabul. She was still pursuing the appellant article 8 claim in respect of his private life and his family life with his cousin and his family "(at [21).

16. The factual findings made by FtTJ Farrelly can be summarised as follows.

(1) The claimed interest by the Taliban related to his elder brother. It was suggested he came from a large family, but the appellant was the only one said to have relocated to Pakistan. Even there he claimed not feel safe but given his lack of profile there was no apparent interest why the Taleban would be interested in the appellant. The previous judge rejected the claim based on his cousin's claim of fortuitously finding a threatening notice in a mosque. His cousin, like the appellant was not found to be credible at the earlier hearing. The rejection of this was not challenged. However, the threat has not been established and therefore there was no specific reason why the appellant could not return to his home area (at [50]).

(2) The judge rejected his claim of having no family in Afghanistan with whom he was in touch with. The FtTJ set out that the appellant had indicated he is from a large and close family. His cousin's and cousin's wife are from the same area and that both claim they have no relatives to return to. The FtTJ stated "I do not find this established" (at [51]).

(3) "His cousin returned on no fewer than five occasions. I find it incredible that he would make no enquiries about the appellant's family, given the claim made. His explanation that he did not have the telephone number is not credible. Furthermore, the appellant himself has made no effort. Again, I do not find

credible and reject his claim that he is unaware of his family. No explanation has been given as to why he can no longer make contact. He stated that his father was educated and employed as a teacher. His cousin indicated that he had two sisters living in Kabul. It is my conclusion that the appellant has support in both Kunduz and Kabul" (at [52]).

(4) At [61] the FtTJ concluded "I do not accept his claim that he has lost touch with his family. Given that his underlying claim has been rejected I start by considering if he can return to Kunduz. I reject his claim that he has no close family. His cousin is in the same area and has repeatedly returned there. It seems likely that his family would still be there as well as extended family members. His family can support him when he returns. His cousin here can also do so."

(5) In the alternative, the appellant could relocate to Kabul. The FtTJ found that "I believe it likely he also has extended family members there. His cousin referred to his sisters being there, and he has returned there in the past. It seems likely that they could also provide the appellant with support" (at [62]).

(6) The FtTJ considered the medical evidence but found that there was nothing that would prevent the appellant re-establishing himself in his home country, particularly with the support of his family. There was no active risk of self harm and his claim had not been advanced on that basis (at [63]).

(7) At [65], the judge accepted that he presented as someone suffering from "anxiety and depression" and that the healthcare professionals had accepted his account of events at face value and appropriate referrals have been made. He had attended 12 sessions of cognitive behavioural therapy; he engaged in his mood and improved. There was reference to the stress of ongoing appeals over his status. The judge stated, "I accept that the appellant has the mental health issues but do not accept the background circumstances are as he claims."

(8) At [66] the judge considered the country information about Afghanistan's health system and at [67], on the basis of his finding that his family were in Kunduz, the FtTJ concluded that he could return there or in the alternative relocate to Kabul, where his cousin had visited and where he indicated he had two sisters "I am not satisfied that they have disappeared without trace" (at [67].

(9) In respect of article 8, the FtTJ did not find that family life existed between the appellant and his cousin. He accepted that he had a private life but that there would be no difficulties with him reintegrating to Afghanistan.

17. The appeal was therefore dismissed. An application for permission to appeal was made which was granted on 4 November 2019.

18. The appeal came before Upper Tribunal Judge Dawson on 17 January 2020. As can be seen from his decision there were 5 grounds advanced before the Upper Tribunal.

(1) Ground one: based on unfairness, was not pursued before the UT ((see [8]).

(2) Ground 2: asserted that the FtTJ incorrectly categorised the purpose of the medical evidence which was being presented to support the appellant's credibility. Its purpose was to establish that the appellant would be unable to relocate to Kabul in the light of his mental health issues. The medical evidence was considered only after the question of credibility was determined.

(3) Ground 3: argued that the judge erred by considering the medical evidence on the basis of the appellant not having been credible and rejecting it.

(4) Ground 4: argued an inconsistent finding by the FT J that the appellant had some mental health issues in the context of his acceptance that the appellant was suffering from major depressive disorder.

(5) Ground 5: argued a failure by the judge to apply AS (safety of Kabul) Afghanistan CG [2018] UKUT 00118 as it was still under appeal but nevertheless treated it as the extant country guidance. Because of the recent UNHCR guidelines it is arguable that the very clear conclusion in the guidelines left no room for doubt (that given the current security, human rights and humanitarian situation in Kabul, and IFA/IRA is generally not available in the city).

19. The UTJ therefore considered grounds 2-5.

20. As to Ground 2, the UTJ set out paragraph [21] of the FtTJ and that he had expressly stated that counsel was not seeking to reargue any of the previous negative credibility findings.

21. At [11] the UT observed that at [61] the FtTJ did not accept the appellant's claim to have lost contact with his family and thus "echoing the earlier finding on this aspect by FtTJ Buchanan who explained at [40] of his decision.

22. At [13] the UTJ considered the psychiatric evidence (which consisted of two reports by Dr Hopley dated 15 September 2017 and 26 June 2019) and noted that both reports were "predicated on the appellant's claim no longer pursued of a fear of trouble from the Taliban, but also an absence of contact with any family members." The UTJ recorded the submission made by Mr Hussain that the report should be treated as objective evidence of the appellant's claim to have lost contact. UTJ Dawson rejected that submission finding that "in my judgement this is a misunderstanding of the role of medical evidence. The judges focus was on the diagnosis, and he was entitled to explain his assessment of that medical evidence at [65]. Bearing in mind the reduced weight he was able to give to the medical evidence, in my judgement judge Farrelly was entitled to reach the conclusion on the issue of contact with family members, notwithstanding the appellant's continued assertion that this had been lost."

23. As to ground 3, and the argument that the judge had reached a conclusion not open to him on the basis of the medical evidence, the UTJ rejected that ground finding it had "no merit". The UT found that the judge was entitled to assess the medical evidence in the light of the concession regarding preserved previous negative credibility findings and was rationally entitled to characterise the appellant's mental health issues as he did (at [14]).

24. Dealing with ground 4, the UT stated that the ground did not disclose error by the judge in his approach the medical evidence and his assessment on the impact that evidence were the appellant to be returned (at [15]).

25. As to ground 5, the UTJ recorded that the original grounds of appeal to the FTT were examined which included "reliance on a risk with reference to increasing violence sufficient to engage article 15(c) ". The UTJ considered that the judge was required to consider the issue of article 15 (c) in relation to the appellant's home area of Kunduz, which if established would require consideration of internal relocation to Kabul (at [16]).

26. The UT concluded:

> "17. Although this aspect was not argued as a ground, nevertheless it is Robinson obvious that such consideration will be required before examining whether the appellant would be able to return to Kabul as an alternative. On that latter aspect it is not clear whether the judge treated AS (safety of Kabul) Afghanistan CG [2018] UKUT as continuing country guidance. To the extent that he did, that in my judgement was an error as the case has been remitted to the Upper Tribunal for its further reconsideration.
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> 18. I am persuaded therefore that these aspects require further consideration. I set aside the decision of Judge Farrelly solely on this basis. The previous negative credibility findings continue to be preserved and I also preserve Judge Farrelly's finding that he remains in contact with his family members in Kunduz. The remaking of the decision will be confined to consideration whether there is an Article 15(c) risk for the appellant were he to be returned to Kunduz to re-join his family members, and if so whether internal relocation is reasonably available to Kabul. It is open to the appellant to obtain further evidence on his mental health. For such further evidence to be of assistance, it is essential that the author is aware of the negative credibility findings and the existence of family in the home area."

27. The UT therefore set aside the decision of FtTJ Farrelly to be listed for a further hearing in the Upper Tribunal once the decision in AS (Afghanistan) had been promulgated.

The resumed hearing before the Upper Tribunal:

28. The hearing was listed before the tribunal as a resumed hearing on the 9 June 2021.

29. In the light of the COVID-19 pandemic the Upper Tribunal issued directions after hearing the advocates who had indicated that the appeal could be determined with a face-to-face hearing, with the appellant giving evidence.

30. Both parties having indicated that they were content for the hearing to proceed by this method. Therefore, the Tribunal listed the hearing on that basis and following the agreement of both advocates.

31. Shortly before the hearing, the Tribunal was informed that there was a difficulty in attending court and therefore further representations were sought from the parties. The tribunal was informed that it was agreed by the appellant's solicitors that the

hearing could be heard by way of a remote hearing and arrangements were made for the appellant to attend at his solicitors office for his evidence to be given via remote means with all other parties attending remotely. I was present at the Court building along with the Court Clerk.

32. The Upper Tribunal has issued directions on the 29 January 2021 and set out the issues as follows:

(1) For the purposes of the remaking of the decision, the Upper Tribunal has preserved the previous negative credibility findings and FtTJ Farrelly's finding that the appellant remains in contact with his family members in his home area (as set out at [18] of UTJ Dawson's decision).

(2) The issues the Upper Tribunal in remaking the appeal are as follows:

(a) whether the appellant faces a real risk of breach of Article 15 (c) of the Qualification Directive were he to return to his home area, including the viability of travelling there.

(b) the reasonableness of internal relocation to Kabul.

(3) It was agreed by the advocates that the appellant would give further oral evidence relating to the issues identified at paragraph 2 above through a Pashtu interpreter.

The re-making decision before the Upper Tribunal:

33. At the resumed hearing both parties were represented by advocates; the Appellant was represented by Mr Hussain of Counsel who had represented the appellant previously and the Respondent by Mr Diwnycz, Senior Presenting Officer.

The evidence:

34. The Appellant's solicitors had provided a copy of the bundle of documents which included an expert country report from Mr Foxley, medical evidence in the form of 2 psychiatric reports in 2017 in 2019, GP records, letters from the GP and those involved in treatment. In addition there were 2 reports from the treating psychologist and an updated report from Dr John. The bundle also included country materials relevant to Afghanistan and past evidence that had been before the tribunal. There was also a witness statement from the appellant.

35. The Respondent relied upon the material in the Respondent's bundle.

36. Country evidence was filed on behalf of the respondent:

Afghanistan-Background Note-v1.0(December 2020) (publishing.service.gov.uk)

Afghanistan. Medical and Healthcare CPIN.v1.0.December 2020 (publishing.service.gov.uk)

37. Directions were made by the Upper Tribunal for both parties to file skeleton arguments. Neither party complied with those directions.

38. I have had regard to the medical reports when undertaking the hearing and also in the assessment of the appellant's evidence.

39. I have also reminded myself of the case of the case of AM (Afghanistan) v Secretary of State for the Home Department [2017] EWCA Civ 1123 in which Sir Ernest Ryder, Senior President, referred to the Joint Presidential Guidance Note No. 2 of 2010: Child, Vulnerable Adult and Sensitive Appellant ("the guidance note") and also the Practice Direction, First-tier and Upper Tribunal Child, Vulnerable Adult and Sensitive Witnesses. He went on to state that "the directions and guidance contained in them are to be followed and Failure to follow them will most likely be a material error of law".

40. Paragraph 2 of the Guidance Note states that, when considering whether an individual is vulnerable, any mental health problems, his or her social and cultural background and any domestic circumstances are to be taken into account. In the Appellant's case, there is expert evidence from a psychiatrist who makes reference to his mental health problems and his diagnosis. The report confirms that he is fit to give evidence before the Tribunal.

41. On the basis of this evidence, and as both advocates accept, I find that the Appellant is a vulnerable witness and whilst the Tribunal did not receive any communication from the advocates as to any special measures that may be necessary I was satisfied from speaking to the advocates at the hearing that steps were taken to ensure he was able to give evidence in accordance with the Guidance and in the light of the report.

42. The Home Office Presenting Officer had discussed with Counsel prior to the hearing the circumstances. No questions were asked in evidence in chief and in cross examination questions were given in a calm and measured manner and if anything was unclear, questions were rephrased. I set out that if any breaks in the proceedings were required that could be accommodated at any time. In any event the oral evidence given was of a very short duration and I was satisfied that the Appellant was able to participate fully in the hearing and no concerns were raised during the hearing in this respect.

43. The appellant adopted his witness statements as his evidence in chief. The last one was dated 3 July 2019; there was no updated statement. In cross examination he was asked about his evidence and that the witness statements in effect restated his history in Afghanistan in the UK. The appellant agreed that that was the position. As to his claim loss of contact with the family in Afghanistan he was asked if his representative had contacted the Red Cross. The appellant stated that they had not. He was asked if there any reason why that had not been done and the appellant stated that he was frightened and that if he contacted his family he would put everyone in danger by giving his personal details. He was asked if he had discussed it with a solicitor and he said that he had not and that he was really frightened and did not want to share his personal details with anyone. He said that he had never heard of the red Crescent.

44. No further oral evidence was given.

The submissions:

Submissions on behalf of the respondent:

45. Mr Diwnycz on behalf the respondent stated that the decision letter in this appeal was out of date and that the current country guidance case of AS (Afghanistan) had not been promulgated when the decision letter had been drafted. He stated that in the decision and now that the policy of the respondent was that all enforced returns were to Kabul and Kabul only.

46. In relation to the medical evidence, Mr Diwnycz accepted that Dr John was an expert who had come to a series of conclusions. He did not seek to make any further submissions on the content of her report save for the observation that she failed to make any mention of the more up-to-date evidence relating to mental health and psychiatric treatment available in Afghanistan. The references in her report were out of date relying upon a 2002 Lancer report and in 1999 report.

47. No further submissions were advanced.

Submissions on behalf of the appellant:

48. As regards the medical evidence, Mr Hussain submitted that the authors of the reports were obvious experts and had applied their opinions and diagnosis consistently to demonstrate that the appellant suffered from serious mental illness including PTSD. Despite the direction of UTJ Dawson, there was no suggestion that the appellant was feigning any of his symptoms and Dr M had provided to reports of the treatment that he was providing to the appellant. Similarly the report of Dr John properly assessed the appellant and sets out the historical evidence relied upon including a review of the GP records which went back months and years. Thus he submitted there was a long history and presentation of psychological symptoms presented by the appellant.

49. Mr Hussain directed the tribunal's attention to the previous reports of Dr Hopley, the long history and presentation of symptoms which included sleep disturbance and also the risk of suicide. He submitted that whilst he accepted that self-reporting was diagnostic, the doctor had referred to the depression inventory and his expertise led him to reach the conclusions she did at pages 12 to 13. Thus he submitted the reports describe someone who was confirmed to suffer from PTSD with suicidal ideation with a high level of risk and that when coupled with the expert country material set out in the report of Mr Foxley it painted a depressing picture for return to the appellant's home area or Kabul. Mr Hussain accepted that Mr Foxley did not have access to any up-to-date medical evidence but that having looked at the report of Dr John who reviewed the historic psychiatric evidence, Mr Foxley's report was still valid as to circumstances in Kabul.

50. As to return to Afghanistan, Mr Hussain submitted that there is an inconsistency on the respondent's part because the policy position was return only to Kabul because

the respondent could not show that anywhere else was safe. When looking at return to the appellant's home area, it would be necessary to assess the problems in that area and its safety and this was not addressed in the decision letter nor in any oral submissions during the hearing. He submitted that the route of return was important and that had not been addressed by the respondent.

51. By reference to the expert report of Mr Foxley he relied upon the particular pages of that report at 38 – 42 dealing with the home area of the appellant showing the highly fluid circumstances and that it was unstable and erratic. Paragraph 52 referred to risk of return to the home area. He submitted that in terms of the home area, the passages set out in the report provided a picture of insecurity and risk from the Taleban and risks of recruitment.

52. Mr Hussain submitted that he was not trying to argue that there was a generalised article 15 (c) risk in Afghanistan but that as a result of the appellant's vulnerabilities and that the experts confirmation that the trigger for his PTSD's experiences in the past having witnessed horrific killings mutilations and that they would be triggers to a relapse in his mental health and risk of self-harm were sufficient factors to demonstrate that he met the "sliding scale".

53. Mr Hussain submitted that paragraph 77 of the report made reference to family support and in cross examination it was raised that he could contact the Red Cross. Whilst the previous findings of credibility were relevant, as set out in the report of Mr Foxley the appellant has been away from Afghanistan since 2010. Further reference was made to the report in terms of lack of housing, quality of housing, the job market and the informal economy, the issues of westernisation and paragraph 96 the "trust issues" where strangers are viewed with suspicion and this need to be considered in relation to his vulnerabilities.

54. Mr Hussain relied upon the conclusion at paragraph 155 as to the circumstances in Kunduz and the problems identified in Kabul. The appellant had been away from Afghanistan for over a decade and had no experience of living or travelling or working in Afghanistan alongside having mental health problems which were key factors as risks on return.

55. As to the availability of treatment, by reference to the CPIN dated December 2020 there was limited information as the availability of treatment and no specific treatment was identified at paragraph 12.2.1 and 12.2.2. This was relevant to the appeal because the appellant's treatment regime was one that had kept him well and was not present in Afghanistan and that was highly relevant to any prospect of relocation as set out in AS (Afghanistan) at paragraph 252 where an individualised assessment should be made on a "case to case basis". When applying those factors he submitted that it was important to take into account his age when he left Afghanistan and in this case he was a minor and that he had not lived in Afghanistan for over a decade.

56. In addition his mental health played a significant part in assessing relocation. The appellant had spent the vast majority of his adult life in the UK. Mr Hussain made

reference to the lack of housing and as to the availability of employment of paragraphs 228 – 230, and it would depend on the appellant's health and characteristics. There were descriptions of people competing for jobs and that the appellant did not have connections to assist him in this regard and thus would be unable to sustain himself. Also due to his mental health problems he would be disadvantaged in the employment market and if he had a relapse would not be able to support himself. The appellant also does not have a Tazkera.

57. As to the risk of suicide, the medical evidence supported the high risk for the appellant and whilst the protective factors of his family in the UK was identified that would not be present if he were removed. The appellant would not have the support network he required. He submitted that the appellant would succeed in article 3 grounds in this regard.

58. Mr Hussain submitted that the evidence demonstrated that it would be unduly harsh for the appellant to relocate to Kabul.

59. At the conclusion of the hearing I reserved my decision which I now give.

Analysis of the evidence:

60. I have set out above that it is common ground between the parties that the Appellant is a vulnerable witness by reason of his mental health condition. I have therefore taken account of and applied the Joint Presidential Note. In this context I make reference to the case of *JL (medical reports-credibility) China* [2013] UKUT 00145 (IAC), in particular paragraph 6, which referred to the situation where an Appellant was vulnerable and said that it was of particular importance to take into account the possible relevance of the Appellant being a vulnerable person to the credibility findings. As it was, the oral evidence given by the appellant was limited and there were no submissions made as to the reliability of the earlier factual findings.

61. There is no dispute that the appellant is a national of Afghanistan who entered the UK in June 2010 when he was a minor and made a claim for asylum on 25 June 2010. His claim was refused but was granted discretionary leave to remain on the basis that he was an unaccompanied minor. I have set out earlier the litigation history and the factual findings made by each of the tribunal judge's concerned.

62. The Upper Tribunal expressly preserved the previous findings made by two FtTJ's concerning the appellant's factual claims and that this included the finding that the appellant would be at no risk of persecution or serious harm from the Taleban or any other person in his home area in Kunduz.

63. The second factual set of findings related to the appellant's claim to have lost contact with his family members. Again, as set out in detail above the Upper Tribunal preserved the factual findings made by that the appellant had not lost contact with his family members in Kunduz.

64. Those factual findings form the basis of my consideration of the two issues that are the subject of this resumed hearing. I have new evidence in the appellant's bundle

which I have summarised above. The position in respect of his mental health has also been the subject of a number of reports, including new reports for the purposes of this hearing. I shall therefore set out my analysis of that evidence.

The medical evidence:

65. I had the opportunity of considering the medical evidence relied upon for this appeal. It consists of 2 reports from a consultant psychiatrist, a report from a consultant psychologist specialising in trauma and reports from a clinical psychologist who is involved as the treating clinician. Additionally there are copies of the appellant's medical records and short letters from his GP. There are also letters relating to other treatments such as CBT which had been undertaken during various periods of time. It is not necessary for me to set out all of the medical evidence, which I have read and considered, and I intend to summarise the medical evidence which is provided in the reports of the psychologists and psychiatrists.

66. Dr Hopley, who is a consultant psychiatrist, has provided 2 reports dated 15 September 2017 and 26 June 2019. The 1st report was prepared after having interviewed the appellant in the company of his cousin in August 2017. For the purposes of the 1st report, Dr Hopley had been provided with the medical records which he reviewed at paragraph 7.1 (p432AB) which included a 1st entry on 20 July 2010 with a referral to the community health team and also later on 27 July 2010 was noted to be struggling with flashbacks, feelings of guilt.

67. The psychiatrist opinion was that the appellant had been diagnosed as suffering from a depressive disorder and that his presentation symptoms recorded in the GP records were consistent with a major depressive disorder of moderate to severe intensity and that he was currently being prescribed a high dose of antidepressant medication.

68. The doctor considered the impact on his mental health if he were to stop taking medication would be most likely to be a relapse into a pattern of more severe symptoms and that under those circumstances there was a significant risk of his suicidality increasing. The doctor concluded that he was currently being supported by his family that any removal from that safe and protected supportive environment was likely to have a negative impact on his mental health and risk of suicide. At paragraph 10.4 the psychiatrist referred to return to Afghanistan and that it had appeared from his account that he would be exposed to significant risk of targeted violence at the hands of the Taliban and that this significant environmental change notably impact negatively on his mental health, covering a worsening of his depression and an increase in risk of suicide.

69. The 2nd report was prepared following an interview on 2 April 2019. This interview was carried out after the hearing before the FtT in 2017 but before the UT hearing in 2019. Reference was made in the report to having access to talking therapy in late 2018 and that he saw a therapist over a four-month period which stopped in early 2019.

70. The psychiatric opinion was that the appellant continued to suffer from a major depressive disorder and that he presented with "pervasive lowering of his mood, a

range of depressive cognitions and some biological symptoms including sleep disturbance, psychomotor retardation, lack of motivation and drive. The appellant was taking antidepressant medication daily and there was scope for the dose to be increased. Reference was made to a course of psychological therapy which appeared to be cognitive behavioural therapy for a period of 4 months in late 2018 and whilst that provided improve coping strategies, the depressive symptoms persisted.

71. At paragraph 5.3 (p.479AB), it was stated that the appellant's depressive disorder was perpetuated by his fear of being returned to Afghanistan and his view that his life would be endangered. Reference was made to the positive social and physical support from his family and that the removal from such a caring and safe environment would be "very likely to have a negative impact on his mental health and thereby increase the risk of suicide."

72. There are 2 short letters from the appellant's GP dated 29 May 2018 and 25 June 2019 (436 and 458AB). The 1st letter states "as you can see from the few consultations as man has suffered from severe mental trauma for the following reasons. The GP then set out factual matters which had been undermined by the decisions of the FTT. Similarly, the 2nd letter repeats what is said in the 1st.

73. Dr M who is a consultant clinical psychologist in trauma has prepared two reports dated 29 September 2020 (486AB) and 27 May 2021. The appellant was referred to the service by the team at "talking therapies".

74. His first assessment was conducted over the telephone due to covid-19 restrictions. In the 1st report he reached the conclusion that he believed the appellant to be suffering from post-traumatic stress disorder, depression and ambiguous loss. The appellant stated that he thought he had depression anxiety, but Dr M's opinion was that he suffered from PTSD. The appellant described "intrusive visual memories for events he witnessed in Afghanistan such as beheadings and dead bodies. He told me that he was a teenager when he witnessed these things. He describe reliving memories of these events and added that it felt like it was back there in Afghanistan".

75. Dr M referred to the appellant's account of struggling with nightmares about 2 times a week and dreamt of people getting killed. He described "hypervigilance" and an "exaggerated startle response" and that he always looked over his shoulder when walking down the street. He struggled with concentration and described what sounded like "dissociated experiences".

76. Dr M then set out the appellant's account of what he claimed happened in Afghanistan and Dr M stated "since arriving in the UK has lost contact with his family and he is uncertain of their whereabouts or whether they are alive or dead. His PTSD appears to have been triggered when he lost contact with his family. He began to imagine that they have succumbed to the fate of others, those he had witnessed in his earlier life."

77. Further reference is made to atrocities that he had witnessed as committed by the Taliban (p488) and that at the time he did not think that these events impacted him

and that he pushed them to the back of his mind. Dr M states "he was able to contain these memories into the lost contact with his family, which is when his PTSD symptoms emerged."

78. As to risk, Dr M referred to the appellant having told him that he had strong thoughts of killing himself and that these had been fairly persistent over a number of years. Dr M found that there were 2 main protective factors; 1st his cousin's children and 2nd, he is still uncertain if his family are alive or dead and he noted he wants to find out the answer to this question so doesn't want to kill himself. He has used the crisis team in the past.

79. In summary, Dr M stated that the appellant was suffering from post-dramatic stress disorder, depressed mood within the context of ambiguous loss. Ambiguous loss is a loss that occurs without closure or clear understanding. This kind of loss leaves a person searching for answers and this complicates delay the process of grieving and often result in result grief. The appellant is uncertain of his family whereabouts he does not know how to contact them. Given the interactive nature of his PTSD, depression and ambiguous loss in the contextual factors, he required treatment at a tertiary level service.

80. The 2nd report is dated 27 May 2021. Dr M has now started treatment with the appellant but noted that there had been little improvement over the time he had waited for treatment and that the symptoms and difficulties described in the initial assessment (summarised above) were consistent with the description in May 2021 .

81. Dr M states that in summary the appellant suffers from post-traumatic stress disorder, a major depressive episode and ambiguous loss. He describes the appellant as also struggling with significant ruminative thinking and worry and that sadly he is still had no word about the fate of his family in Afghanistan.

82. Dr M describes the intrusive visual memories described by the appellant that he stated he had witnessed in Afghanistan as a child, which included beheadings and dead bodies and that these events were enacted by the Taliban. He told Dr M that most victims were people who he knew growing up. He described in flashbacks feeling very emotional and that his breathing changed and he sweated. These body-based flashbacks to experiences happened 4 to 5 times a week and he struggled with nightmares 3 to 4 times a week. Dr M also referred to the appellant's intrusive memories triggering ruminative thinking; nearly every day spent time ruminating on what might have had happened to his family. Dr M found this to be a "clinically significant problem and interferes considerably with his day-to-day functioning." Reference is also made to events in Afghanistan and that his father had urged him to leave before he was targeted and killed by the Taliban.

83. Dr M recorded that the appellant "appears to suffer with dissociative episodes probably linked to traumatic memories." Reference is made to the appellant in 2020 feeling that his depression was the main problem that this is influenced by the uncertainty surrounding his family his status. Dr M stated, "he is caught in a dreadful state of limbo with regards his family status in the UK." Further reference is

made to his family in Afghanistan that since arriving in 2010 he has lost contact with his family and is uncertain about their whereabouts. Dr M also stated, "his PTSD appears to be triggered when he lost contact with his family." Dr M later referred to events in the appellant's home area and Afghanistan and that when the Taliban took over his hometown they fought with the government backed troops. When describing the appellant he stated "at the time he did not think the atrocities that he had witnessed had impacted on him psychologically and he told me that he pushed them to the back of his mind. He was able to contain these memories until he lost contact his family, which is when his PTSD systems emerged. In my view he described delayed onset PTSD."

84. As to risk, the same information was recorded as in 2020 that he had strong thoughts of killing himself which been fairly persistent of number of years but that there were 2 main protective factors namely his cousin's children and that he still uncertain about whether his family are alive or dead and wants to find out the answer to this question. He had been given the number of the crisis team details of a text-based service for people in distress.

85. Dr John, a consultant clinical psychologist with a specialism in adult mental health was asked to prepare a report on the basis of the instructions as set out at page 2 of the report. The report is dated 6 June 2021. Dr John records that she had sight of the GP medical records and enclosures dating from 2010 when he arrived at the age of 15 and also to psychiatric reports of Dr Hopley from 2017 and 2019. For the purposes of report, he completed self-report questionnaires which were sent prior to the sessions.

86. From reading the records reviewed for the report it does not appear that Dr John was provided with the previous decisions of the tribunal which had set out the factual findings concerning events in Afghanistan.

87. Dr John provides a summary of her conclusions as follows. The appellant suffers from severe post-traumatic stress disorder with severe depression and anxiety (DSM 5) and ambiguous grief, with a high level of risk to his life. Dr John sets out that he arrived in the UK as a minor at the age of 15 years following targeting of his family by the Taliban and appearing to risk to his own life. He feared that his family may been killed by the Taliban, who destroyed the home just after he fled the country. He is continuing to seek asylum in the UK from the safety of his cousins home. In her opinion the appellant required a course of expert psychological treatment to assist his recovery from the symptoms and reduce the level of risk from self-harm. She believed he would fail to thrive should be removed from the care of his cousin and re-traumatised by being sent back to Afghanistan.

88. Dr John also concluded that the appellant had suffered atrocities through growing up in a war zone and being a member of a family targeted by the Taliban. He had suffered significant trauma due to witnessing these atrocities, due to his belief and worry that his nuclear family may have been killed by the Taliban since his departure in 2010, and in addition, exposed to a traumatic journey to the UK which he was treated inhumanely where he believed that he almost lost his life to hypoxaemia, being pulled unconscious from the freezer lorry by paramedics and

given immediate life-saving treatment. Since attempting to settle in the UK by learning English, junior college course and integrating the community, he said lost the right and education work 7 years ago due to changes in UK Home Office rules. At around that time he also lost contact his family and currently feels they may have been killed.

89. Dr John continues "my assessment finds (MO) to be suffering from severe post-traumatic stress disorder with severe depression and anxiety (DSM5) and I concur with the NHS consultant clinical psychologist Dr M that he is also suffering from ambiguous grief and that in the absence of knowledge of the whereabouts of his family, he is unable to grieve appropriately for the loss of them. For a long period (his) post-traumatic symptoms were not recognised as part of his diagnosis, possibly because his symptoms of depression were prominent, and he was managing to mask the expression of the underlying trauma through a psychological defence. At the point when he lost contact with his family and lost his role as college student with the potential to find work and therefore a meaningful purpose in UK society, his defensive resilience was breached and the key symptoms of PTSD and anxiety became prominent, giving rise to flashbacks, nightmares, symptoms of avoidance and autonomic arousal. In my opinion, for at least the past 7 years he has been suffering from symptoms of severe PTSD as well as severe depression and anxiety. His risk of suicide is currently very high, contained only by his hope that his family are still alive and his supportive relationship with his cousin and his cousin's family. Despite these protective factors he has indicated that he would like to kill himself, he has acted on aspects of his suicide plans on 4 occasions, in my opinion any further stressful experiences would exacerbate that risk.

90. Dr John recommends that he undertake a belated course of psychological therapy with an experienced clinical psychologist in order to address his PTSD with severe depression and anxiety and ambiguous loss. He has just commenced treatment on the NHS but due to the complexity of the ambiguous grief overlaid onto his PTSD insignificant losses, it is likely to require a lengthy course of therapy. Dr John's opinion is that he is currently in need of highly expert treatment for psychological disorder with a clinical psychologist with specialist experience. At paragraphs 480 – 520 Dr John refers to the likely availability of receiving the treatment in Afghanistan by reference to a report dated December 2002. Dr John's opinion is that the information in that report did not adequately address the degree of trauma experienced by the population did not include individualised treatment by a psychologist which is what was required to assist the appellant". A further article referred to at paragraph 520 of the report refers to the failure to train psychiatrists in the country. Dr John is of the opinion that even if the appellant were able to gain timely access to 1 of the initiatives, they amounted to a population based stress reduction technique to "take the edge off" the horrifying traumatic experiences suffered by the residents of Afghanistan and in the absence of psychologists there is no provision of high quality psychological treatment. In contrast, what is required to address extreme trauma and symptoms experienced by the appellant is a "bespoke course of highly skilled, individual psychological therapy with a specialist psychologist experience in the treatment of PTSD and trauma."

91. Dr John states that the appellant has now commenced this course of treatment with a well-respected expert in the field and that to interrupt the level of treatment for which he has been waiting for many years would be highly detrimental to his mental health and likely to significantly increase his risk of suicide. If he were to be deprived of the recommended psychological therapy to meet his needs he would remain in his current traumatised state be both a high risk of suicide and vulnerable to being more significantly impacted by any future stressors.

92. At paragraph 540, Dr John's opinion is that he would be at a severely increased risk of suicide should it be deprived of the protective care of his cousin and family in the UK and that he has no home to return to and that he would not have the resilience to enable him to live alone in an unfamiliar environment surrounded by constant reminders of the atrocities that occurred there, most importantly the established murder of his cousin's father from his village and the loss of his family.

93. As to prognosis, Dr John's opinion is that if the appellant is permitted to continue the course of psychological treatment as commenced with Dr M and granted leave to remain then in time he will be likely to recover from the psychological symptoms of severe PTSD, anxiety and depression and will be able to gain a sense of purpose and hope for the future and integrate within UK society. In this case the high risk of suicide will be significantly reduced. Dr John considers that it may take between 6 to 12 months to see significant improvement. However if he was to return to Afghanistan he would be deprived of the necessary treatment for his condition and would also be retraumatised by being in the environment where he experienced the atrocities. Her opinion is that he would be of significant risk of failure to thrive and of completing suicide on hearing the outcome of his appeal or shortly there afterwards.

Conclusions on the medical evidence:

94. The Court of Appeal has provided guidance on the issue of evidence from medical experts in the recent case of MN and others v Secretary of State for the Home Department [2020] EWCA Civ 1746 ("MN and others") as follows:

> "21. In our view the law as appears from those authorities (so far as relevant to the issues in these appeals) can be summarised as follows:
>
> (1) The decision whether the account given by an applicant is in the essential respects truthful has to be taken by the tribunal or CA caseworker (for short, the decision-maker) on the totality of the evidence, viewed holistically - *Mibanga*.
>
> (2) Where a doctor's opinion, properly understood, goes no further than a finding of "mere consistency" with the applicant's account it is, necessarily, neutral on the question whether that account is truthful - see *HE (DRC)*, but the point is in truth obvious.
>
> (3) However, it is open to a doctor to express an opinion to the effect that his or her findings are positively supportive of the truthfulness of an applicant's account (i.e. an opinion going beyond "mere consistency") ; and where they do so that opinion should in principle be taken into account -

> *HK*; *MO (Algeria)*; and indeed, though less explicitly, *Mibanga*. In so far as Keene LJ said in *HH (Ethiopia)* that the doctor in that case should not have expressed such an opinion (see para. 117 (1) above), that cannot be read as expressing a general rule to that effect.
>
> (4) Such an opinion may be based on physical findings (such as specially characteristic scarring). But it may also be based on an assessment of the applicant's reported symptoms, including symptoms of mental ill-health, and/or of their overall presentation and history. Such evidence is equally in principle admissible: there is no rule that doctors are disabled by their professional role from considering critically the truthfulness of what they are told - *Minani; HK*; *MO (Algeria); SS (Sri Lanka)*. We would add that in the context of a decision taken by the CA on a wholly paper basis, a doctor's assessment of the truthfulness of the applicant may (subject to point (5) below) be of particular value.
>
> (5) The weight to be given to any such expression of opinion will depend on the circumstances of the particular case. It can never be determinative, and the decision-maker will have to decide in each case to what extent its value has to be discounted for reasons of the kind given by Ouseley J at para. 18 of his judgment in *HE (DRC)*.
>
> (6) One factor bearing on the weight to be given to an expression of opinion by a doctor that the applicant's reported symptoms support their case that they were persecuted or trafficked (as the case may be) is whether there are other possible causes of those symptoms. For the reasons explained by Ouseley J (*loc. cit.*), there may very well be obvious other potential causes in cases of this kind. If the expert has not considered that question that does not justify excluding it altogether: *SS (Sri Lanka)*. It may diminish the value that can be put on their opinion, but the extent to which that is so will depend on the likelihood of such other causes operating in the particular case and producing the symptoms in question."

95. When dealing with evidence of physical injury, a medical expert can provide more definitive evidence as to likely causes which in turn is likely to provide stronger corroboration (or not) of an account. It stands to reason that determination of the cause of mental trauma depends to a greater extent on the account given and, for that reason, on the credibility of the person giving the account.

96. In terms of the presence of any mental disorder, diagnosis often relies upon a combination of the history the patient gives, objective evidence of symptoms in an interview situation with the psychiatrist and corroborative evidence of symptoms by independent witnesses. Very few mental disorders are diagnosed on the basis of objectively observed symptoms only. Post-Traumatic Stress Disorder is the mental disorder most commonly diagnosed amongst refugees and asylum seekers. For PTSD to be diagnosed, however, there has to have been a trauma. In the case of many asylum seekers, there is not always concrete proof that a trauma has occurred and frequently, as in this case, the existence of the trauma is called into question.

97. Whilst it appears that neither Dr John nor Dr M had been provided with copies of the tribunal's assessment of the evidence and the adverse factual findings made, I am

satisfied that the diagnosis that has been reached by each of those experts, alongside the earlier reports of Dr Hopley, and in the context of the medical records, is one that merits weight. In this respect I note that Judge Farrelly, when assessing the reports of Dr Hopley accepted the underlying conclusions of the reports and the diagnosis provided (at paragraph 58) irrespective of the underlying cause of those symptoms of mental illness.

98. In this respect I accept the submission made by Mr Hussain that there has been a consistent thread of the medical evidence, which is supported by the medical records, which indicates that the appellant is suffering from mental illness as described in the most recent report of Dr John and the treating clinician. As he submitted, despite the caveat set out at paragraph 18 of UTJ Dawson's decision, the experts are well versed in considering whether someone is faking symptoms and that in the light of the reports that I have read given that level of description and consistency over a long period of time, it is unlikely in my view that the appellant is feigning his symptoms.

99. The medical records indicate that upon arrival in the UK in July 2010 the appellant was referred to the community health team and was later observed to be struggling with flashbacks, and feelings of guilt (see p.432AB) and as evidenced in the GP referral letter to the child mental health services, the appellant required support in coping with his traumatic experiences. His symptoms included flashbacks, intrusive thoughts, tearful, headaches. It is recorded "arrived in refrigerated lorry with 16 others, some unconscious through hypoxaemia, heat exhaustion. Sense of responsibility for younger compatriots."

100. In 2012 the referral form notes that he had been referred for counselling. In February 2015 a screening test showed significant scores for depression and for anxiety and in March 2015 he was referred to high intensity operative behavioural therapy and at the time was taking antidepressant medication. The therapists reported a high risk of suicide, and he was given details of emergency mental health services. The plan was to monitor his risk through therapy sessions and plans were drawn up (p.433AB). In 2016 there were mental health reviews and in 2018 the GP records make reference to having developed a depressive illness. In 2019 he attended 12 sessions of therapy (454AB) but the continued insert of his circumstances contributed to a deterioration in his mood. In 2019 whilst coping strategies had improved his dispersive symptoms persisted.

101. The medical records therefore demonstrate that the appellant has had varying degrees of mental health problems since arrival as a minor age 15 in 2010. I observe that when the FTT heard the appeal in 2012 there was no medical evidence presented on the appellant's behalf despite what was in his records. In 2017 the judge was presented with medical evidence which the judge accepted as did judge Farrelly in 2019 although whilst he accepted the diagnosis, judge Farrelly did not accept the underlying causes of his mental health condition.

102. The most recent report of Dr John demonstrates the appellant's previous diagnosis of severe depression has altered and for a prolonged period of time his post-traumatic

symptoms had not been recognised as part of this diagnosis possibly because his symptoms of depression were prominent and that he was managing to mask the expressions of underlying trauma through a psychological defence (at para.479).

103. Whilst Dr John refers to the trauma based on the appellant's evidence and loss of contact with his family and not by reference to the factual findings made by the earlier tribunals, there is reference to the significant trauma experienced by the appellant both having witnessed atrocities in Afghanistan which are described in the flashbacks, nightmares and sleep disturbances at paragraph 270 and also by reference to the traumatic journey to the UK which included being pulled unconscious from a refrigerated freezer lorry and having been given life-saving treatment. It is also recorded that since being in the UK he lost his right to education work as a result of changes in her office policy alongside the claimed loss of contact with his family.

104. Some of those experiences of trauma are referenced in earlier evidence such as the appellant's journey which took 18 months in Afghanistan at a time when he was a child and being transported in a freezer lorry (see the 2010 medical report). As to the circumstances in his home area, the relevant country materials at the time demonstrated that the Taliban were operating with impunity in the area and the appellant's descriptions of the general conduct and treatment of the inhabitants of that area are consistent with what is known of the Taliban. Whilst the previous FtTJ's did not accept that the appellant had been specifically targeted there were no adverse findings made as to the general conduct of the Taliban in those areas and in my view the appellant's description and presentation is supported by the description of his mental health going back to 2010 and as such is consistent with those aspects of trauma.

105. Therefore whilst the medical evidence is based partially on the claimed events in Afghanistan specifically to him and the lack of contact with family members which the tribunal rejected, there are incidents of trauma which the appellant has experienced, and which is consistent with earlier evidence which are likely in my view to account for the diagnosis which has been made and one which I accept.

106. Mr Diwnycz on behalf of the respondent accepted that Dr John was an expert who had come to a series of conclusions. He did not seek to make any further submissions on the content of her report save for the observation that she failed to make any mention of the more up-to-date evidence relating to mental health and psychiatric treatment available in Afghanistan. There was no challenge to any of the medical evidence.

<u>Article 15 (c) and the appellant's home area:</u>

107. I now deal with the issue raised of Article 15 (c).

<u>Humanitarian Protection</u>

108. Notwithstanding the United Kingdom's withdrawal from the European Union, the 'minimum standards' of protection set out in the Qualification Directive continue to find expression in the Immigration Rules:

> 339C. A person will be granted humanitarian protection in the United Kingdom if the Secretary of State is satisfied that:
>
> (i) they are in the United Kingdom or have arrived at a port of entry in the United Kingdom.
>
> (ii) they do not qualify as a refugee as defined in regulation 2 of The Refugee or Person in Need of International Protection (Qualification) Regulations 2006.
>
> (iii) substantial grounds have been shown for believing that the person concerned, if returned to the country of return, would face a real risk of suffering serious harm and is unable, or, owing to such risk, unwilling to avail themselves of the protection of that country; and
>
> (iv) they are not excluded from a grant of humanitarian protection.
>
> 339CA. For the purposes of paragraph 339C, serious harm consists of:
>
> (i) the death penalty or execution.
>
> (ii) unlawful killing.
>
> (iii) torture or inhuman or degrading treatment or punishment of a person in the country of return; or
>
> (iv) serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of international or internal armed conflict.

109. As the Upper Tribunal noted in *AA (unattended children) Afghanistan CG* at [35], the starting point in considering a claim for humanitarian protection under Article 15(c) is the decision of the ECJ in *Elgafaji* (Case C-465/07), [2009] 1 WLR 2100. After reviewing the three types of 'serious harm' defined in Article 15, the judgment of the ECJ in *Elgafaji* continued:

> "35. In that context, the word 'individual' must be understood as covering harm to civilians irrespective of their identity, where the degree of indiscriminate violence characterising the armed conflict taking place assessed by … the courts of a member state to which a decision refusing … an application [for subsidiary protection] is referred, reaches such a high level that substantial grounds are shown for believing that a civilian, returned to the relevant country or, as the case may be, to the relevant region, would, solely on account of his presence … face a real risk of being subject to the serious threat referred to in Article 15(c) of the Directive."

110. The personal circumstances of an individual were also addressed by the Court:

> "39. In that regard the more the applicant is able to show that he is specifically affected by reason of fact as particular to his personal circumstances, the lower

> the level of indiscriminate violence required for him to be eligible for subsidiary protection."

111. As to the circumstances in Kunduz, the appellant relies upon the report of Mr Foxley dated 10 November 2020 ((14AB). It is not in dispute that Mr Foxley is able to provide a country expert report and he has provided such evidence before the tribunal hearings as indicated in his report. Mr Diwnycz on behalf of the respondent does not dispute his expertise. Additionally the respondent has not sought to advance any criticisms of that report during this hearing.

112. I have carefully read and considered the report and the overview of the country background relevant to Afghanistan set out by Mr Foxley at paragraphs 8 – 23 which is consistent with the known history of the country and that it is a country which has been the subject of complex and protracted conflict for over 4 decades.

113. At paragraph 7, the report touches on the withdrawal of the US military by May 2021 and that whilst talks had commenced with the Taliban and the Afghan government violence had resumed although at the date of the report (November 2020) at a lower level but that the situation was described as "highly fragile" and that the "attack levels are increasing". At paragraph 24, reference is made to the Taliban envisaging their further role and that in the next 6 to 12 months conditions would be tense with "the security situation remaining fragile" (at paragraph 25).

114. Since the report and at the date of the hearing, the US troops had withdrawn from Afghanistan and the violence that was foretold has indeed resumed with the Taleban having taken more territory from the Afghan government forces and now having a strong presence across Afghanistan including major cities such as Kunduz, Herat, Kandahar and Lashka Gah. The Taleban has forced government forces to abandon some district administrative areas and others have been taken by force. There are reports from the UNHCR that a new wave of internal displacement has occurred across the provinces of Ballackshan, Kunduz, Baghlan and Takhar (see BBC reports June 2021).

115. Against that background I accept the view expressed in the report at paragraph 31 that whilst there had been a reduction in casualties in 2020 when compared to 2019 it is not sufficient to indicate a long-term improvement in the security situation. However Mr Hussain on behalf of the appellant does not seek to assert that there is internal armed conflict in Afghanistan but seeks to demonstrate that the appellant by reason of his own personal characteristics would be at an enhanced risk in his home area.

116. The appellant's home area is also expressly considered in the report of Mr Foxley at paragraphs 32 – 57. The history of the Taleban and fighting in the Kunduz province is summarised at paragraph 41 – 49. There is no dispute that the Taliban have had a significant presence in Kunduz for many years and that they managed to overrun and capture the city in September 2015.

117. In the earlier paragraphs, Mr Foxley sets out the general violence occurring more or less in every part of Afghanistan and the difficulty in pinpointing and predicting

which districts are controlled by the government and those which are controlled by the Taliban (paragraph 33). He states that violence levels were still high in 2020 and produced a map showing the spread of attacks across the country in October 2020 from the Afghanistan analysts network which shows that every province is suffering from conflict -related violence. That also includes the appellant's home area. Reference is made at paragraph 42 the home area and the areas controlled by the Taliban and that for an ANP station at Kunduz city northern gate, fighting is almost a daily occurrence and that the presence of Taleban fighters and checkpoints on the major roads has arguably been the greatest change since the Doha talks. The Taliban were described as stopping vehicles, taking mobile phones, calling recently dialled numbers and telling those on the other end their friend been involved in an accident. They would then ascertain relevant personal details that would determine whether the passenger had government affiliations and whether such a person should be allowed to continue on their journey or not.

118. More recent evidence that deals with the circumstances in 2020 demonstrated that assessments at that time continued to show a Taleban presence and at paragraph 51 Mr Foxley sets out a non -exhaustive selection of Taliban -related security incidents in Kunduz in early November 2020 and that the reporting comes from a credible Afghan news agency Pajhwok news.

119. Against that background and the particular characteristics of the appellant, I have considered whether the appellant would be at an enhanced risk in his home area. I am required to base that assessment on the factual findings made by the previous tribunal that the appellant has not been at risk of harm from the Taliban based on his previous account. However whilst that is the starting point of my assessment, I take into account the identified risks to him as set out in the report of Mr Foxley. Whilst the circumstances leading to his departure from Afghanistan were not accepted, the country materials demonstrate that whatever those circumstances were there is a reasonable likelihood that on return to his home area the perception may be that he was a member of an anti-Taliban family, that he had rejected them and had fled to a western country. In this context I take into account that the appellant left Afghanistan well over a decade ago as a child and would be returning back as a young adult and that his return after such a significant period would be likely to give rise to interest in him and likely to be viewed with adverse interest by the Taleban, their supporters and sympathisers. I take into account that whilst he still retains his knowledge of language, given the length of time that he has been absent from Afghanistan, it is likely that he would have lost some linguistic fluency and local knowledge. Mr Foxley's opinion is that such adverse interest would likely involve illegal detention at best and execution at worst.

120. As to a generalised risk based on his length of absence, whilst I have not been addressed as to any specific aspects of the appellant's conduct or behaviour, I would accept Mr Foxley's general assertions that in rural parts of the country where there are more conservative Islamic values and the Taleban often dominate (such as in the appellant's home area) any cultural differences which would be apparent whether through accident, clothing or behaviour, may cause him to be of adverse interest. I do

not consider that the evidence before me demonstrates that there is a risk from "westernisation" or any adverse targeting because of a perceived connection to the West but that in his home area there is a reasonable likelihood that after such a prolonged absence, his presence may stand out and thus give rise to an enhanced risk.

121. Whilst the appellant's account of not being in contact with his family has been disbelieved and this forms the basis of my factual assessment I have considered whether it is right for me to conclude positively that support will be available from a particular individual or that there is a particular type of support that any family member would be able to provide. No evidence has been advanced in this respect nor has there been any submission behalf of the respondent as to what support would be available other than in the very generalised sense.

122. I have accepted the medical evidence advanced on behalf of the appellant for the reasons that I have set out earlier. Mr Hussain directed my attention to the evidence which demonstrated that there is a stigma attached to mental health (see Mr Foxley's report). However that appears to be the position where the manifestation of the illness is obvious and present. On the facts of this case, there is no evidence to support that view nor is there evidence to suggest that the appellant's remaining family would not offer support for him as a result of any mental illness. However, I am satisfied that he is a vulnerable individual who has been outside of Afghanistan for over a decade and left as a child and would be returning as an adult. He would not be returning in the circumstances in which he left given the level of his mental illness. For the reasons already set out, having been out of the country for that length of time and the age that he left, it is reasonably likely in my view that he will be the subject of adverse interest. Whilst I do not accept that he would be targeted on account of previous problems with the Taleban in accordance with the factual findings made by the tribunal judges, he may nonetheless be at risk as a result of his return and given his vulnerability which may not now give him any social skills to avoid a risk of harm. Mr Foxley describes the appellant's home area as a conservative area and given the presence of Taleban as recently confirmed, there is a likelihood of adverse interest being shown in him.

123. Having made that assessment I therefore apply the legal principles I have set out above in Elgafaji and that the more an applicant is able to show that he is specifically affected by reasons of factors particular to his personal circumstances, the lower the level of indiscriminate violence required.

124. Having applied that decision, I am satisfied that on the evidence before me the appellant has demonstrated particular characteristics and vulnerability which included the age when he left Afghanistan and the length of time that he has spent outside of his home area. I have found the appellant to be a vulnerable individual due to his mental health and even with family support (of whatever nature which is not particularised further) when those factors are considered together it demonstrates in my judgement that there is enhanced risk to him when viewed alongside the country evidence relating to Kunduz. In reaching that finding I place some weight on the submission made by Mr Hussain that had not been argued on

behalf the respondent that he would be able to travel to his home area safely given the risks of violence and travelling the distance from Kabul (the place of return) to the home area. As Mr Hussain submitted Kabul is the only place of enforced return and Mr Diwnycz confirmed that to be the position.

Internal Relocation

125. Paragraph 339O headed "Internal Relocation "states:

'i. The Secretary of State will not make:

(a) a grant of asylum if in part of the country of origin a person will not have a well-founded fear of being persecuted and the person can reasonably be expected to stay in that part of the country; or

(b) a grant of humanitarian protection if in part of the country of return a person would not face a real risk of suffering serious harm, and the person can reasonably be expected to stay in that part of the country.

ii. In examining whether a part of the country of origin or country of return meets the requirements in i. the Secretary of State, when making his decision on whether to grant asylum or humanitarian protection, will have regard to the general circumstances prevailing in that part of the country and to the personal circumstances of the person.

iii. It applies notwithstanding technical obstacles to return to the country of origin or country of return."

126. In considering the proper approach to the issue of internal relocation I have also to apply the principles set out by the House of Lords in Januzi [2006] UKHL 5 (which adopts the criteria now contained in paragraph 339O but also contains more detailed guidance) and AH (Sudan) [2007] UKHL 49.

127. In Januzi their Lordships held that the test for whether it would be unreasonable for an asylum seeker to relocate to a safe haven within his own country, was not whether the quality of life there failed to meet the basic norms of civil, political, and socio-economic human rights, but whether he would face conditions such as utter destitution or exposure to cruel or inhuman treatment, threatening his most basic human rights. There was no presumption that when persecution emanated from agents of the state or where the state encouraged or connived in that persecution by others, there could be no viable internal flight option. The greater the power of the state over all parts of the asylum seeker's country the less viable such an option would be and vice versa.

128. In AH (Sudan) their Lordships repeated that the test to determine whether internal relocation was available was as set out in Januzi namely whether it was reasonable to expect the Appellant to relocate or whether it would be unduly harsh to expect him to do so. The 'unduly harsh' test did not require conditions in the place of relocation to reach the Article 3 ECHR level. The inquiry was to be directed to the situation of the particular Appellant, whose age, gender, experience, health, skills, and family ties might all be very relevant. Cases had to be assessed holistically with specific reference to personal circumstances, including past persecution or fear thereof in family and social relationships.

129. Having reached the conclusion the appellant cannot return safely to his home area, I am required to consider whether it is unduly harsh for him to internally relocate to Kabul.

130. The two country guidance cases of AS (Safety of Kabul) Afghanistan CG [2018] UKUT 118 (IAC) and AS (Safety of Kabul) Afghanistan CG [2020] UKUT 130 (IAC) considered the reasonableness of return and relocation to Kabul. The Upper Tribunal considered whether it was reasonable to expect a claimant to relocate, or whether it would be unduly harsh to expect him to do so. Whether or not it will be unduly harsh for the appellant to relocate to Kabul depends on a number of factors which have been outlined in the above country guidance decisions to which I have had regard. The country guidance decisions make it plain that I am required to consider each case on its own particular factual matrix and on a "case-by-case assessment".

131. In AS (Safety of Kabul) Afghanistan CG [2020] acknowledged the widespread and persistent conflict related violence in Kabul but stated that the proportion of the population affected by indiscriminate violence was small and not at a level where a returnee, even one with no family or other network and who has no experience of living in Kabul would face a serious and individual threat to their life or person by reason of indiscriminate violence. Safety and security were factors but not determinative. The Tribunal in 2020 reviewed the changing position from the 2018 country guidance with regard the reasonableness of return and, (save for the specific areas of challenge), found the position largely the same. Whilst Mr Foxley refers to risk on the basis of general safety in Kabul and by reference to the UNHCR guidelines (August 2018) at paragraph 58, that evidence was considered in detail in AS (Afghanistan) as such, Mr Foxley's conclusion on this aspect does not lead me to depart from the CG decision nor did Mr Hussain invite me to do so. I am also satisfied that the generalised violence referred to in Mr Fox's report at paragraph 64 – 77 also does not lead me to depart from the country guidance caselaw. Again, Mr Hussain does not seek to argue that there is an article 15 (c) risk in Kabul.

132. Nor do I find that there is any risk of the appellant being specifically targeted by the Taliban and this is supported by Mr Foxley's report at paragraph 74, 76 and his conclusion at 136 – 137, given the past factual findings and that his profile is low.

133. The Tribunal in AS having regard to the security and humanitarian situation in Kabul as well as the difficulties faced by the population living there, found it would not in general be unreasonable or unduly harsh for a single adult male in good health to relocate to Kabul even if he does not have any specific connections or support network in Kabul but nonetheless, that the particular circumstances of an individual applicant must be taken into account.

134. The real issue I have to consider is the issue of support and the provision of treatment for mental health and whether there are any other particular characteristics that are relevant to the issue of relocation and whether it would be unduly harsh in the light of those identified factors. I have set out a summary of the medical evidence that has been provided on behalf of the appellant and I accept the diagnosis provided for the reasons that I have given. None of that evidence has been challenged by the

respondent during the hearing. According to that evidence, the appellant has commenced a course of treatment with a clinical psychologist and Dr John's opinion is that to interrupt the level of treatment would be highly detrimental to his mental health and likely to significantly increase his risk of suicide. That risk would further increase in the light of any change from the protective factors identified as being the care of his family in the UK. The treatment that is required for the appellant is said to be between 6 to 12 months to see a significant improvement but that without that treatment he would be retraumatised by being in the environment where he experienced the atrocities (paragraph 560 of Dr John's report and prognosis). Whilst Dr John had made reference to the factual circumstances which the previous tribunal had rejected, I have concluded for the reasons set out earlier that the appellant has likely been subject to trauma whilst in Afghanistan on a different basis therefore that prognosis is still relevant.

135. I accept Mr Diwnycz's submission that the report of Dr John (where she refers to the lack of treatment in Afghanistan) is reliant upon out-of-date material and therefore I attach no weight to that. Mr Foxley in his report sets out access to medical care generally at paragraphs 112 – 115 and deals with mental health care at paragraph 116 – 120 and also addresses the security situation and the impact on access to healthcare at paragraph 121. Additionally there is the impact of the covid- 19 virus (paragraphs 128 – 134).

136. The respondent relies upon the material in the CPIN. Paragraph 12 of that document relates to mental health provision.

Mental health

137. General availability of mental health care facilities in Afghanistan

> 12.1.1 Human Rights Watch (HRW) observed in a report of October 2019: 'Afghanistan has been devastated by violence, and it is estimated that half the population experiences depression, anxiety, or post-traumatic stress, which can have a disastrous impact on people's mental health and the well-being of their relatives and friends. 'Over the past 15 years, the government has trained roughly 750 psychosocial counsellors who can provide basic mental health counselling and facilitate referrals. But less than 10 per cent of the population [uses] these services.' 96 12.1.2 The WHO Afghanistan Country Office 2019 report noted: 'Despite significant need, healthcare facilities attending to mental health issues are scarce. Mental health is one of the components in the existing framework of the Basic Package of Health Services (BPHS). Inclusion of mental health and psychosocial care into BPHS is an important step towards ensuring that psychosocial problems and mental disorders are recognized and managed by primary healthcare personnel. Currently, psychosocial counsellors provide services in most comprehensive health centres (CHCs). The lack of trained psychiatrists, psychiatric nurses, psychologists and social workers presents a serious challenge for mental healthcare service delivery.'
>
> 12.1.3 Regarding facilities for inpatient psychiatric care, the WHO Mental Health Atlas for 2017 showed that there was one mental hospital in the country

and four general hospitals with psychiatric units. The mental hospital accommodated 2,447 inpatients, of whom 881 were admitted involuntarily. 93 MedCOI, 15 January 2020 94 MedCOI, 15 January 2020 95 MedCOI, 11 July 2019 96 HRW, 'Afghanistan's Silent Mental Health Crisis', 7 October 2019 97 WHO, Afghanistan Country Office 2019, (page 19), 2019 98 WHO, 'Mental Health Atlas 2017', 2017. Page 25 of 38 26%-50% of discharged inpatients receive a follow-up outpatient visit within one month99 .

12.2 Availability of specialist treatment in Kabul

12.2.1 MedCOI confirmed, in response to recent enquiries, that the following treatments available at the Ali Abad Hospital, Kabul University, Kabul (a public hospital): • inpatient treatment by a psychiatrist100 • outpatient treatment and follow up by a psychiatrist101 • psychiatric long term clinical treatment (e.g. for chronic psychotic patients) by a psychiatrist102 • psychiatric crisis intervention in case of suicide attempt103 • psychiatric clinical treatment in a closed ward/setting (not necessarily forced admittance)104

12.2.2 MedCOI also noted that inpatient or outpatient treatment and follow-up by a psychologist is available at the Mental Health Hospital, Alauddin, Karte 3, Kabul (a public facility) 105. 12.2.3 Regarding the duration of inpatient psychiatric treatment, MedCOI noted: 'The situation about the maximum duration of the treatment varies: Ali Abad Hospital keeps a patient up to 12-14 days in the clinic. The Mental Health Hospital hospitalizes a patient for up to two weeks. In case of medical need and based on the response of the treatment, they rarely extend the duration to one or very rarely to two weeks more (so in very rare cases hospitalization is possible up to one month).''After that, [the] patient can be visited by a psychiatrist and prescribed with required medicines in Ali Abad Psychiatric department, Kabul, on a regular basis but as an outpatient; so living at home and visit[ing] the department regularly.'

Cost of specialist mental health treatment

12.3.2 MedCOI, in a response dated 29 October 2020, gave the following examples of treatment costs in Kabul as of 21 October 2020: • Outpatient treatment by a psychiatrist (public hospital): Free, apart from AFN 20 registration fee (all medicines must be paid by the patient, except in emergency cases. Lab tests and diagnostic investigations are not free). • Inpatient treatment by a psychiatrist (public hospital): Free, apart from AFN 200 admission fee (all medicines must be paid by the patient, except in emergency cases. Lab tests and diagnostic investigations are not free) • Outpatient treatment by a psychiatrist (private facility): AFN 200 per consultation. • Outpatient treatment by a psychologist (public hospital): Free, apart from AFN 20 registration fee (medicines, lab tests, and diagnostic investigations are not free) • Outpatient treatment by a psychologist (private facility): AFN 500 per consultation. • Psychiatric treatment of PTSD by means of cognitive behavioural therapy (public hospital) Free, apart from AFN 20 registration fee. • Psychiatric treatment of PTSD by means of cognitive behavioural therapy (private facility) AFN 400 per session109

12.3.3 MedCOI reported in May 2019: 'All treatments are available free of charge at the psychosocial and mental health centre in Kabul that is run by IPSO (International Psychosocial Organization). This organisation is funded by the German government to help returned Afghan migrants, but it also provides psycho-social help to the local population. The centre has 2 psychiatrists, 26 psychosocial counsellors, 1 MD and 6 occupational therapists. '[P]atients have to buy the prescribed medications from outside the centre. Patients with low financial means receive the medicines from the clinic free of charge.'

12.4 Available medication

12.4.1 MedCOI specified in recent responses that the medicines listed below were found to be available in Afghanistan: Antidepressants (including drugs for major depressive disorder): amitriptyline111, citalopram112, clomipramine113, duloxetine114, fluoxetine hcl115, fluvoxamine116, imipramine117, mirtazapine118, nortriptyline119, sertraline120, venlafaxine121. Anxiety (anxiolytics), panic disorders, sleeping problems: alprazolam122, chlordiazepoxide123, diazepam124, lorazepam125, oxazepam126, promethazine127, temazepam128, zolpidem129, zopiclone130. Bipolar disorder (manic depression): quetiapine131, sodium valproate132. Psychotic disorders (incl. schizophrenia): amisulpride, aripiprazole133, clozapine134, olanzapine135, paliperidone136, quetiapine137. Seizures, epilepsy: clonazepam138, lamotrigine139, levetiracetam140, pregabalin141, sodium valproate142, valproic acid143. Other: biperidene144, orphenadrine145, temazepam146, trihexyphenidyl147.

12.5 Cultural and social factors: stigma

12.5.1 Human Rights Watch noted in October 2019, 'The health-seeking behaviour of Afghans with mental health conditions is influenced by individual, cultural and structural barriers, ranging from poor knowledge about health and available services to poverty, social exclusion, stigma, gender discrimination and the ongoing conflict.' 148 12.5.2 Dr Manizha Ashna, co-founder of the Women's Health and Welfare Organization in Afghanistan, stated in an article published by Khaama Press News Agency in March 2019: '[P]eople suffering [with poor mental health] tend to hide the maladaptive behaviour, emotional illness, or psychological distress that requires treatment. Social taboos constitute one of the main barriers preventing sufferers' access to mental health services in Afghanistan. The widespread stigma tied to mental disorders jeopardizes the development and implementation of mental health policy. Stigmas and discrimination are barriers that make intervention for treatment difficult, especially in rural areas of Afghanistan. '[M]ental disorders are one of the most misunderstood afflictions in Afghan society as they are exclusively tied to traditional medicine practices and irrational beliefs. In most cases, people who are mentally ill are treated by mullahs and, in severe cases, they are brought to traditional healing centers. 'There are some cultural and social barriers that deny most victims access to mental health services, such as… lack of support from family members and friends, and self-stigmatization due to people's negative and inaccurate believes about mental illnesses.'

> 12.5.3 According to a 2017 article by Dr Ayesha Ahmad, who was then an academic specializing in mental health, culture, and psychological trauma at London University: 'The suffering of mental illness is Afghanistan is a silent war. The causes of such suffering are shrouded in stigma, creating further wounds for the individual, and often their families too. 'Understanding the manifestation of psychiatric disorders such as psychosis, schizophrenia, or seizures related to severe depression carries beliefs about weak faiths or curses. In turn, these beliefs de-humanizes the person. Their identities are replaced by associations with the supernatural.'

138. Whilst the evidence demonstrates that mental health treatment is available (12.2.1 and 12.2.2) and that medication that the appellant is prescribed is also available, overall the evidence demonstrates that was there is some mental health provision such facilities are scarce and there is a lack of trained psychologists and psychiatrists and that this presents a serious challenge to mental health services delivery. There was one mental health hospital in Afghanistan and that the lack of availability of mental health provision in my view has to be seen in context of the large numbers who are in need of such treatment.

139. There is no dispute that physical and mental health is an important factor and the CG decision makes reference to the "very high levels of mental health problems in Afghanistan" which create "significant needs" (at [241]), there is a lack of trained professionals and "inadequate infrastructure" (at [241].

140. I have taken into account the evidence of Dr Ahmad as set out in the decision in AS which is also reported in the CPIN. Dr Ahmed's view of the lack of mental health assistance in Kabul was described as consistent with the views expressed by the UNCHR and other objective material and in particular that there were a large number of people who suffered from undiagnosed and untreated mental health problems, [146], that public healthcare is poor quality medications frequently counterfeit and that the psychiatric services are "inadequate". Her evidence was that there is "little understanding of mental health" and "people with mental health conditions are stigmatised and socially ostracised" (at [83]).

141. Dr Ahmed set out at [83] that there were inadequate psychiatric services and only one mental health hospital in Afghanistan which has only 60 beds for inpatients and 40 in a separate facility for drug addicts. That assessment is not undermined by the recent 2020 CPIN.

142. Based on that evidence, it is likely that the appellant will not be able to access the type of medical health provision for his condition that he requires as evidenced in the report of Dr John. The treatment that he is currently undertaking is not described in the objective material as available, and I place some weight on the evidence which suggests that one of the most concerning areas emerging from research is that relating to the mental health of young, forced returnees (at paragraph 116). It follows in my view that the appellant will have little or no option or resources to access the healthcare that he requires in respect of the trauma which has resulted in his diagnosis of PTSD.

143. The Tribunal in AS remarked upon the socio-economic conditions to be experienced with regard work, which is a critical factor to avoid destitution, as follows:

> *'229. ... Even a person who is unable to form any such connections, and who must survive without the benefit of a network, will ordinarily be able to find inexpensive accommodation in a "chai khana" and (depending on physical abilities, health, and other individual characteristics) be able work as a day labourer in the informal labour market in Kabul.*
>
> *230. A returnee with a support network or specific connections in Kabul may be in a significantly stronger position than others and in some cases the availability of a network will counter a particular vulnerability of an individual on return".*

144. That said, secure rather than temporary employment was said to be dependent upon connection and

> *'Whether a particular returnee would be able to earn sufficient income from this type of work [manual day labourer work] will depend on the individual circumstances. As the available work would mostly be manual in nature, it is necessary to consider whether an individual would be capable (e.g., in the light of his age, health, physical capabilities and other factors) of undertaking such work and would be able to present himself in a way that would attract employers, who frequently will be selecting individuals from a pool of men (some bringing their own tools) who congregate at known meeting points'.*

145. The appellant has mental health difficulties and is a vulnerable adult. Whilst he has some educational qualifications from the UK he has no work experience having left Afghanistan as a child. His mental health condition is such that this would also negatively affect his ability to obtain employment and there is no reference to the appellant having any employable skills or ones that would elevate him above other individuals seeking employment in Kabul.

146. As to family support, the factual findings which were preserved referred to the appellant having family members in Afghanistan and that he had not established that he had lost contact with them (see para.50 Judge Farrelly). As far as can be ascertained, the appellant's cousin had sisters in Kabul although his cousin's evidence was that they had left the city. No further evidence has been adduced as to family contact and it is the appellant's stated position that he had had no contact with his family and it has been this which has led in part to the physical manifestations of his mental health. As set out earlier, the fact that he has family does not necessarily demonstrate that this would provide him with the positive support necessary in the light of his mental health condition or in terms of general support in an area of relocation where he had previously never lived or visited. No evidence was given before the previous tribunal as to any financial and social circumstances of any family who might be there. The level of support that any family members could provide in Kabul is not known given that it is not his immediate family who reside there.

147. The issue of age is also relevant to the issue of internal relocation and the reasonableness of this. The decision in AS [2020] when considering the

reasonableness of internal relocation to Kabul accepted that without a network or connections returnees of any age could expect significant challenges and in relation to age observed as follows:

> *"246. The Panel in the 2018 UT decision identified that a returnee's age, including the age at which he left Afghanistan, is relevant to reasonableness. We agree. Returnees of any age without a network will face significant challenges establishing themselves in Kabul. A person who left Afghanistan at a young age may, depending on individual circumstances, be less able than someone who spent their formative years in Afghanistan to navigate the challenges of the city by, for example, finding work and accommodation.*
>
> *Conclusion on reasonableness*
>
> *247. Taking a holistic view, and considering all of the circumstances together, we are satisfied that generally it would not be unreasonable for a single healthy man to relocate to Kabul, even if he does not have any family or network in the city and lacks a Tazkera. However, in all cases an individualised case-by-case assessment is required, taking into account an individual's personal circumstances including factors such as his age, health, disability, languages spoken, educational and professional background, length of time outside of Afghanistan, connections to and experience of Kabul and family situation and relationships."*

148. The UT in the earlier decision AS (Afghanistan) 2018 stated:

> *"232. We also consider the age at which a person left Afghanistan to be relevant as to whether this included their formative years. It is reasonable to infer that the older a person is when they leave, the more likely they are to be familiar with, for example, employment opportunities and living independently.*
>
> *233. Although we find that it is reasonable for a person without a support network or specific connections in Kabul or elsewhere in Afghanistan to internally relocate to Kabul, a person will be in a more advantageous position if they do have such connections depending on where they are, the financial resources of such people and their status/connections. We have in mind that the availability of a support network may counter a particular vulnerability of an individual on return."*

149. Applied to the circumstances of this case, I have reached the overall conclusion that it has been demonstrated that it would be unduly harsh for the appellant to relocate to Kabul and I have considered the relevant factors which when taken cumulatively support that conclusion. The appellant left Afghanistan when he was a minor child and has been absent from that country for over a decade. He is not a healthy man but someone who is a vulnerable adult by reason of his mental health. The vulnerabilities I have outlined in the earlier part of this decision (when considering return to his home area) also apply to the assessment of relocation. He has no work experience although he has some qualifications obtained in the UK. I accept that he is likely to have some financial support via a grant on return although that would only assist him in the short term. He has no personal connections or experiences in Kabul, and whatever family support that might be available to him there is not from his immediate family and that they have had no face-to-face contact with for a

significant period of time. There is a likelihood that given his type of mental health problems any remaining family may struggle to assist him with any problems that he has whilst there and that is recognised by the general stigma attached to those with mental health conditions notwithstanding the large numbers who appear to have those conditions. I am not satisfied that he would be able to reintegrate to life in Kabul and society there without undue hardship for the reasons set out above.

150. For those reasons I am satisfied that the appeal should be allowed on humanitarian protection grounds.

Article 3:

151. Mr Hussain on behalf of the appellant relies upon the medical evidence advanced on behalf of the appellant in the reports set out in the bundle. It is submitted that the evidence points to the appellant being at a high risk of suicide should he be returned forcibly to Afghanistan.

152. There is no dispute as to the applicable legal principles.

153. The Court of Appeal decisions in *J* and *Y (Sri Lanka)* govern a discrete area of assessment under Article 3 relating to suicide risk. The decisions in *J* and *N* were heard at around the same time in May 2005. By that time, the Court of Appeal in *J* handed down its decision, it had the benefit of the House of Lords decision in *N*. The Court of Appeal conducted a detailed review of the European and domestic case law.

154. The six points it drew from these authorities for the purpose of assessing Article 3 in the context of suicide risk were:

> "26. First, the test requires an assessment to be made of the severity of the treatment which it is said that the applicant would suffer if removed. This must attain a minimum level of severity. The court has said on a number of occasions that the assessment of its severity depends on all the circumstances of the case. But the ill-treatment must "necessarily be serious" such that it is "an affront to fundamental humanitarian principles to remove an individual to a country where he is at risk of serious ill-treatment": see *Ullah* paras [38-39].
>
> 27. Secondly, a causal link must be shown to exist between the act or threatened act of removal or expulsion and the inhuman treatment relied on as violating the applicant's article 3 rights. Thus in *Soering* at para [91], the court said:
>
> > "In so far as any liability under the Convention is or may be incurred, it is liability incurred by the extraditing Contracting State by reason of its having taken action which *has as a direct consequence the exposure of an individual to proscribed ill-treatment.*"(emphasis added).
>
> See also para [108] of *Vilvarajah* where the court said that the examination of the article 3 issue "must focus on the foreseeable consequences of the removal of the applicants to Sri Lanka..."
>
> 28. Thirdly, in the context of a foreign case, the article 3 threshold is particularly high simply because it is a foreign case. And it is even higher

> where the alleged inhuman treatment is not the direct or indirect responsibility of the public authorities of the receiving state, but results from some naturally occurring illness, whether physical or mental. This is made clear in para [49] of *D* and para [40] of *Bensaid.*
>
> 29. Fourthly, an article 3 claim can in principle succeed in a suicide case (para [37] of *Bensaid*).
>
> 30. Fifthly, in deciding whether there is a real risk of a breach of article 3 in a suicide case, a question of importance is whether the applicant's fear of ill-treatment in the receiving state upon which the risk of suicide is said to be based is objectively well-founded. If the fear is not well-founded, that will tend to weigh against there being a real risk that the removal will be in breach of article 3.
>
> 31. Sixthly, a further question of considerable relevance is whether the removing and/or the receiving state has effective mechanisms to reduce the risk of suicide. If there are effective mechanisms, that too will weigh heavily against an applicant's claim that removal will violate his or her article 3 rights."

155. The first three points set out the basic requirements to show a breach of Article 3. The third point made clear that there is an enhanced threshold in cases that come within the *N* paradigm. The last three points went beyond the decision in *N* to consider the context in cases involving the assessment of suicide risk.

156. The Court of Appeal in the *Y (Sri Lanka)* modified the fifth point as follows:

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

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

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

state, the feared harm clearly meets the minimum level of severity required i.e. intense mental suffering leading to their imminent death.

159. The fifth and sixth points highlighted in *J,* modified in *Y (Sri Lanka)*, simply focus the assessment on issues specific to the circumstances relating to suicide risk. First, an initial assessment of whether there is a real risk that the person is likely to commit suicide if returned to the receiving state. This would normally be assessed with reference to expert psychiatric evidence. Second, whether effective measures can be put in place before, during and after removal to reduce the risk of suicide below a real risk. This would normally be assessed with reference to evidence relating to the circumstances in the receiving state."

160. The focus of the assessment in a case involving potential suicide risk is not usually the threshold but whether the evidence shows that there is a real risk of suicide happening before, during or after removal of the person to their country of origin.

161. In *AM (Zimbabwe) v SSHD* , [2019] UKSC 17 the decision contains an analysis of the ECtHR decision in *Paposhvili v Belgium* [2017] Imm AR 867. In particular, the Supreme Court clarified what was meant by the modest extension of the *N* test at [183] of the ECtHR decision with reference to:

> "... situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy."

162. The Supreme Court did not make specific findings relating to the effect of *Paposhvili* on the assessment of suicide risk. Consequently, the substantive Article 3 issues discussed in *AM (Zimbabwe)* do not alter the position relating to the six-point approach outlined in *J*. The nature of the risk of suicide is likely to meet the *N* paradigm or the *Paposhvili* extension for the reasons I have already given.

163. The focus of the assessment is usually on the likelihood of suicide happening, taking into account relevant medical evidence and any evidence relating to the availability of support and treatment that might ameliorate the risk.

164. The Supreme Court identified several procedural requirements outlined by the ECtHR in *Paposhvili* at [23] and went on to analyse the decision as follows:

> "32. The Grand Chamber's pronouncements in the *Paposhvili* case about the procedural requirements of article 3, summarised in para 23 above, can on no view be regarded as mere clarification of what the court had previously said; and we may expect that, when it gives judgment in the *Savran* case, the Grand Chamber will shed light on the extent of the requirements. Yet observations on them may even now be made with reasonable confidence. The basic principle is that, if you allege a breach of your rights, it is for you to establish it. But "Convention proceedings do not in all cases lend themselves to a rigorous application of [that] principle ...": *DH v Czech*

Republic (2008) 47 EHRR 3, para 179. It is clear that, in application to claims under article 3 to resist return by reference to ill-health, the Grand Chamber has indeed modified that principle. The threshold, set out in para 23(a) above, is for the applicant to adduce evidence "capable of demonstrating that there are substantial grounds for believing" that article 3 would be violated. It may make formidable intellectual demands on decision-makers who conclude that the evidence does not establish "substantial grounds" to have to proceed to consider whether nevertheless it is "capable of demonstrating" them. But, irrespective of the perhaps unnecessary complexity of the test, let no one imagine that it represents an undemanding threshold for an applicant to cross. For the requisite capacity of the evidence adduced by the applicant is to demonstrate "substantial" grounds for believing that it is a "very exceptional" case because of a "real" risk of subjection to "inhuman" treatment. All three parties accept that Sales LJ was correct, in para 16, to describe the threshold as an obligation on an applicant to raise a "prima facie case" of potential infringement of article 3. This means a case which, if not challenged or countered, would establish the infringement: see para 112 in *AXB v Secretary of State for the Home Department* [2019] UKUT 397 (IAC). As the tribunal explained at paragraph 123, the arrangements in the UK are such that the decisions whether the applicant has adduced evidence to the requisite standard and, if so, whether it has been successfully countered fall to be taken initially by the Secretary of State and, in the event of an appeal, again by the First-tier Tribunal.

33. In the event that the applicant presents evidence to the standard addressed above, the returning state can seek to challenge or counter it in the manner helpfully outlined in the judgment in the *Paposhvili* case at paras 187 to 191 and summarised at para 23(b) to (e) above. The premise behind the guidance, surely reasonable, is that, while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state. What will most surprise the first-time reader of the Grand Chamber's judgment is the reference in para 187 to the suggested obligation on the returning state to dispel "any" doubts raised by the applicant's evidence. But, when the reader reaches para 191 and notes the reference, in precisely the same context, to "serious doubts", he will realise that "any" doubts in para 187 means any serious doubts. For proof, or in this case disproof, beyond *all* doubt is a concept rightly unknown to the Convention.

165. The procedural issues discussed in *AXB,* and *AM (Zimbabwe)* clarify the usual principles relating to the assessment of a human rights claim. The overall burden of proof is on the appellant to produce evidence to show that there are substantial grounds for believing that there is a real risk of serious harm amounting to a breach of Article 3. The threshold is high in health cases if the risk does not emanate from the authorities in the receiving state. It is thus open to the respondent to produce evidence to show that appropriate health care or other effective mechanisms are available to reduce the risk of Article 3 ill-treatment below a real risk.

166. I have set out my assessment of the medical evidence earlier. For the reasons that I have given, I consider that the reports written by the medical experts should have weight attached to them and I am satisfied that both Dr Hopley and Dr John have the relevant expertise to reach the opinions that they have. As the treating clinician I also attach weight to the report of Dr M. The reports make reference to the earlier material set out in the medical records which refer to the suicidal ideation of the appellant and that this is not recent but has been raised consistently. The evidence supports the view that his position has not improved and that the risk described as a" high risk" remains and I conclude that there is cogent evidence to show a high risk of suicide on return and therefore there is sufficient evidence to demonstrate a risk of him reaching the threshold set out in in the decision of J v SSHD (as set out above).

167. I recognise that the threshold is high in health cases if the risk does not emanate from the authorities in the receiving state. It is therefore open to the respondent to produce evidence to show that appropriate health care or other effective mechanisms are available to reduce the risk of Article 3 ill-treatment below a real risk. Savran v Denmark (57467/15) also makes it clear that the authorities must consider the extent to which the individual in question will *actually* have access to this care and these facilities in the receiving State.

168. There has been no reference in the submissions made on behalf of the respondent to demonstrate that there are effective mechanisms available in Afghanistan to reduce any risk of article 3 ill-treatment below a "real risk". I was provided with an electronic reference to the CPIN but no submissions were made as to how that related to any article 3 risk.

169. Mr Hussain on behalf of the appellant relies upon the objective material which demonstrates a lack of adequate mental health care provision in Afghanistan which is consistent with the respondents CPIN Afghanistan: security and humanitarian situation and health care provision and by reference to the CG decision in *AS (safety of Kabul) Afghanistan* CG [2020] UKUT 00130.

170. When considering the latest country guidance decision, I observe that the tribunal stressed the importance of a fact specific assessment by reference to the returnee's personal characteristics. It is stated that in all cases an individualised case-by-case assessment as required, taking into account an individual's personal circumstances including factors such as his age, health, disability, languages spoken, educational and professional background, length of time outside of Afghanistan, connections to an experience of Kabul and family situation and relationships (at[252]). Whilst this is not in the context of article 3 considerations, in my judgement it has some relevance when addressing this issue.

171. Even if the appellant has family support, I am not satisfied that it is such that it would be sufficient to assist him in re-establishing any form of life in Afghanistan or importantly to access the important mental health provision that he requires or to provide him with the support upon return to reduce the "real risk" of article 3 harm.

172. For those reasons I am satisfied that there is a real risk of article 3 ill-treatment and therefore his appeal is allowed on human rights grounds (Article 3).

173. If I were wrong in that assessment, for the reasons set out earlier, I am satisfied that it would be unduly harsh for him to relocate to Kabul and therefore the appellant is entitled to humanitarian protection.

Decision:

The decision of the First-tier Tribunal did involve the making of an error on a point of law and the decision is set aside; the appeal is re-made as follows: the appeal is allowed on humanitarian protection grounds and on Article 3 grounds.

Direction Regarding Anonymity – Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008

Unless and until a Tribunal or court directs otherwise, the Appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him. This direction applies both to the Appellant and to the Respondent. Failure to comply with this direction could lead to contempt of court proceedings.

Signed

Date: 27/7 / 2021

Upper Tribunal Judge Reeds