Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: HU/03481/2020**

THE IMMIGRATION ACTS

Heard remotely at Field House via video (Teams) **On the 31 January 2022**	**Decision & Reasons Promulgated** **On the 28 February 2022**

Before

UPPER TRIBUNAL JUDGE BLUM

Between

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Appellant

and

MD YAKUB BHUIYAN
(ANONYMITY DIRECTION NOT MADE)

Respondent

Representation:
For the appellant: Mr M Diwnycz , Senior Home Office Presenting Officer
For the respondent: Mr M Hasan, case worker of Lexwin Solicitors

This decision follows a remote hearing in respect of which there has been no objection by the parties. The form of remote hearing was by video (V), the platform was Microsoft Teams. A face-to-face hearing was not held because all issues could be determined in a remote hearing and because of a request by one of the parties based on medical grounds.

DECISION AND REASONS

1. This is an appeal against the decision of Judge of the First-tier Tribunal Roots ("the judge") who, in a decision promulgated on 27 July 2021, allowed the human rights appeal of Mr MD Yakub Bhuiyan ("the

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respondent") against the decision of the Secretary of State for the Home Department ("the appellant" or "SSHD") dated 13 November 2019 refusing his human rights claim made on 4 October 2016.

Background

2. The respondent is a national of Bangladesh, born on 1 August 1984. He entered the UK on 15 December 2010 with entry clearance as a Tier 4 (General) Student, valid until 31 March 2012. The college with which he was studying had its licence revoked and, unable to find a new college, the respondent became an overstayer.

3. The respondent's human rights claim was based on his medical condition and the private life he had established in the UK. The respondent was diagnosed with schizophrenia in Bangladesh in 2008, and again in the UK in December 2011. According to a letter from his GP dated 2 September 2016, and another letter dated 11 October 2019, he was considered a 'vulnerable adult'.

4. In her decision refusing the human rights claim the appellant noted the respondent's medication (Kemadrin tablets and Risperidone tablets), and that his condition had previously been managed in Bangladesh. The respondent applied the principles enunciated in N v SSHD [2006] UKHL 31 [2005] UKHL 31 and found that the respondent's condition did not meet the high threshold in an Article 3 ECHR medical treatment claim, and that the respondent could obtain healthcare and continue managing his condition in Bangladesh. The respondent appealed the appellant's decision pursuant to s.82 of the Nationality, Immigration and Asylum Act 2002.

The decision of the First-tier Tribunal

5. The judge had before him a bundle of documents prepared by the respondent's solicitors that included, *inter alia*, a statement from the respondent dated 20 October 2020, copies of the respondent's medical notes printed by the Whitechapel Health Centre on 16 September 2020, a Consultant Psychiatrist letter of 15 August 2013 addressed to the respondent's GP, a letter from another Consultant Psychiatrist dated 21 January 2015 also addressed to the respondent's GP, a letter from Dr John Iyiola of the Newham East London NHS Foundation Trust Community Mental Health Team typed on 9 January 2012, and evidence of the respondent's academic achievements in Bangladesh.

6. Although the judge refused an adjournment application made at the hearing in order to obtain expert evidence, following the hearing the judge decided that expert evidence was necessary. Directions were given to this effect and the expert evidence consisting of a psychologist report from Ms Georgina Costa, a further letter from the

respondent's GP dated 1 June 2021, and a country report from Dr Amundsen were all filed and served on 3 June 2021, together with some background evidence on the health system in Bangladesh and further submissions, and the appellant provided further written submissions on 16 June 2021. The judge heard oral evidence from the appellant at the remote hearing on 19 April 2021.

7. In his decision the judge set out the relevant procedural history and summarised the submissions made by the parties. The judge correctly directed himself as to the appropriate law in respect of Article 3 ECHR medical cases, citing both Paposhvili v Belgium (41738/10) [2017] INLR 497 and AM (Zimbabwe) v SSHD [2020]UKSC 17, and directed himself according to the relevant burden and standard of proof.

8. In the section headed "my findings and reasons" the judge considered the report from Ms Costa setting out several extracts relating to the respondent's description of his hospitalisation in Bangladesh in 2008 and in 2009, and his hospitalisation in February 2013 following a psychotic episode in this country. It was not apparent that Ms Costa was a Clinical Psychologist or that she had particular experience with schizophrenics, but no challenge was levelled against her expertise. Ms Costa stated that the respondent was going to need lifelong mental health support, and that the support of the mental health services and the respondent's friends in the UK were protective factors without which his mental health would significantly deteriorate. It was noted that, despite being on medication, the respondent had several psychotic episodes requiring hospital treatment and ongoing support in the community. The judge accepted that the respondent had been hospitalised in Newham Hospital for 10 to 15 days in 2013, and that he was under the care of his GP and the community mental health team (from time to time). The judge found that the respondent required regular GP appointments so that his health and medication could be monitored and reviewed.

9. The judge referred to the GP letter of 1 June 2021 confirming that the respondent suffered with significant mental health problems and was currently receiving antipsychotic medication, and that he suffered with low mood and a history of suicidal thoughts. The judge found that the respondent was receiving significant care from his GP and additional care from the community mental health team plus social support. The judge noted that some of the details were "vague", and that it was "not entirely clear what support he receives from the community mental health team, nevertheless there is clear expert evidence that he requires the support." Reference was also made to a mental health and well-being care plan detailed in the bundle of documents.

10. The judge then considered the expert country report from Dr Amundsen. The judge briefly summarised the report noting, *inter alia*,

that there was no universal free health care in Bangladesh, that health insurance was practically non-existent, that in rural areas there were very few formally trained providers, that there was corruption in healthcare, that there was severe neglect of mental health illnesses, but mental health services were virtually non-existent at primary care level throughout the country, that a modern sector salary was required and those with schizophrenia tended to lead very poor lives, that those with mental health conditions were likely to be locked up and even chained up due to a lack of understanding, and that family support was essential.

11. The judge summarised the appellant's further written submissions which noted, *inter alia*, that the respondent had a history of mental health issues before arriving in the UK, that he had two episodes of a similar illness in Bangladesh for which he was treated, that the letter from Dr Iyiola referred to details of the respondent's psychiatric admissions in 2008 in Bangladesh, and that there was no reason why the treatment the respondent previously underwent in Bangladesh could not continue if he was returned. The judge also referred to the Country Policy and Information Note (CPIN) 'Medical and Health care issues' (May 2019) which referred to a MEDCOI report from 2015 indicating that 'Risperidone' was available in Bangladesh, and noted, at [43], that the relevant section of the CPIN contained numerous references to few support services being available in Bangladesh and facilities being inadequate, as well as there being considerable social stigma and poor logistical support for those with mental health problems. The judge noted the appellant's submissions that the respondent had four brothers and a sister in Bangladesh, and that medical treatment was available. Reference was made to the appellant's submission that the medication the respondent was using in the UK was "exactly the same as he was using before he left Bangladesh."

12. At [42] the judge noted that the appellant's further submissions did not directly engage with the expert reports, and that the expert evidence was not challenged. At [44] to [46] the judge set out numerous instances referencing the respondent's employment in the UK and found that the respondent had not given a reliable account of his employment in this country.

13. At [47] to [55] the judge referred to the respondent's assertion in his statement that he had an aunt, cousins and extended family members living in the UK but that few details were provided, and at [48] the judge referred to the respondent's assertions that he had little contact with his family in Bangladesh and that it was not possible for his mother to support him as she had "some serious disease". The judge noted however at [49] that the medical records indicated that the respondent's older brother and brother-in-law were his "main support network" and found that the reference to 'brother'

was a brother in Bangladesh. The judge referred to the evidence given in the documents before him to the effect that the respondent had siblings in Bangladesh with whom he maintained good communication, although this related to evidence in 2011. The judge noted the respondent's oral evidence that, although he had siblings, he did not communicate with them due to his mental health. The respondent claimed his siblings did not care for him due to his mental health. At [54] the judge said that "much of the [respondent's] evidence about his family and support in the UK and Bangladesh is very unsatisfactory, inconsistent, and not reliable, even taking into account that he is a vulnerable witness." The judge indicated that he had taken into account the unreliability of the respondent's evidence about any family support that he would be able to access in Bangladesh. The judge noted however that there was clear evidence about stigma attached to mental health in Bangladesh and that even if the respondent had more siblings in Bangladesh the evidence that only his mother was in contact with him was not inconsistent with the background evidence. At [55] the judge found that only the [respondent's] mother was willing to provide him with any meaningful support and that this would be limited due to her age, and the judge accepted that there was a real risk that his siblings would not be able to or willing to provide any meaningful support him on return to Bangladesh.

14. Whilst noting at [57] and [58] that some aspects of the respondent's treatment and support in the UK remained vague, the judge found that the respondent was principally under the care of his GP who monitored his medication and condition regularly, and that there was no reason to doubt the medical evidence from the GP that the respondent had a severe and lifelong mental health condition.

15. Although the judge indicated that he had taken into account the respondent received of medical treatment in Bangladesh prior to 2010 and the related submissions by the respondent, the judge stated,

> "However it is also important of the nature and quality of that treatment in Bangladesh as per the account given to Ms Costa and set out above. That account is consistent with the background evidence and I do not find any reason to doubt it."

16. With reference to the report from Dr Amundsen the judge found, at [62], that despite the inconsistent evidence from the respondent about family support, there was a real risk that the necessary treatment was not available in Bangladesh.

17. At [63] to [64] the judge did not find that the respondent had made out his case that he was at real risk of suicide on return to Bangladesh.

18. At [67] the judge noted that the respondent had worked for much longer periods in the UK than he cared to admit, and that he had more support in Bangladesh then he wished to admit. The judge found however that the respondent's appeal had to succeed under Article 3 ECHR. The judge briefly summarise the principal factors that led to this decision. These included the fact that the respondent had a lifelong severe mental health condition, that he suffered from hallucinations, paranoia and thoughts of deliberate self-harm, that he required medication and regular monitoring from his GP and referrals to the community mental health team from time to time, that he had been hospitalised despite this treatment, that there were significant doubts and a real risk that the respondent would be unable to access the required medication in Bangladesh and that he would be unable to afford to purchase the medication even if it was available, that the treatment that he received in Bangladesh prior to 2010 (as the respondent cited to Ms Costa) amounted to treatment which breached the Article 3 ECHR threshold, and that there was a real risk that he would be subject to this again upon return to Bangladesh. The judge concluded at [68] that the test in AM (Zimbabwe) had been met and the appeal was allowed under Article 3 ECHR.

The challenge to the judge's decision

19. The grounds of appeal are twofold. The first ground of appeal contends that the judge misdirected himself and failed to apply the correct threshold as outlined in AM (Zimbabwe). Having found that the respondent would not face a real risk of suicide on return to Bangladesh, the judge failed to identify the circumstances in which the respondent would face a "serious, rapid and irreversible decline in their state of health resulting in intense suffering or a significant (substantial) reduction in life expectancy as a result of the absence of appropriate medical treatment or lack of access to such treatment and the country on return." The judge failed to identify the irreversible decline or significant reduction in the respondent's life expectancy return to Bangladesh.

20. The second ground of appeal contends that the judge failed to take into account and/or resolve conflicts of fact or opinion in respect of the issue of the respondent medication being available to him on return to Bangladesh. The judge failed to take into account and resolve the appellant's written submission recorded at [41(g)] of the decision which asserted that the respondent had previously received treatment in Bangladesh and that the medication he was using in the UK was exactly the same as he was using before he left Bangladesh, and that he had family who supported him and he would be able to find work using the experience and skills that he had acquired in the UK. The judge had not address the issue that the respondent's current medication was identical to that used by him in Bangladesh, and the judge failed to provide any evidential basis for his findings that the

medication that was previously available to the respondent in Bangladesh, was no longer available to him.

21. In his oral submissions Mr Diwnycz adopted both grounds and submitted that the judge failed to resolve the tension in the evidence before him relating to the treatment the respondent received in Bangladesh.

22. Mr Hasan submitted that it was “obvious” that the respondent would not get adequate medical treatment in Bangladesh and that the only support he would received was from his mother who was old. Mr Hasan accepted that there was no independent evidence relating to the age of the respondent mother. When I asked Mr Hasan to identify in the judge’s decision the nature of the intense suffering that would be experienced by the respondent, given that the judge had found there was no risk of the respondent committing suicide, Mr Hasan indicated that he could not see any specific words or paragraphs in the decision explaining or describing the nature of the intense suffering. Mr Hasan was unable to explain how the judge reached his finding that the previous treatment experienced by the respondent in Bangladesh prior to 2010 constituted a breach of Article 3 ECHR.

23. I reserved my decision.

Discussion

24. In AM (Zimbabwe) (Appellant) v SSHD (Respondent) [2020] UKSC 17 the Supreme Court considered and endorsed the judgment of the Grand Chamber of the European Court of Human Rights (the ECtHR) in Paposhvili v Belgium [2017] Imm AR 867 which gave an expanded interpretation of Article 3 ECHR in the context of medical treatment cases.

25. The appellant in AM (Zimbabwe) was settled in the UK when a deportation order was made against him because of very serious criminal offences. He was also HIV+ and claimed that he would be unable to access the appropriate antiretroviral therapy in Zimbabwe which would cause him to become prey to opportunistic infections and which, if untreated, would lead to his death.

26. The Supreme Court, having analysed Paopshvili and several other judgments, concluded that the Grand Chamber’s pronouncement about the procedural requirements of Article 3 ECHR were not merely clarificatory and that the Grand Chamber had modified the earlier approach in N v United Kingdom (2008) 47 EHRR 39.

27. The formula posited in Paposhvili was that there must be a real risk of a person:

> "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".

28. At [23] the Supreme Court stated:

> "Its new focus on the existence and accessibility of appropriate treatment in the receiving state led the Grand Chamber in the *Paposhvili* case to make significant pronouncements about the procedural requirements of article 3 in that regard. It held
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> (a) in para 186 that it was for applicants to adduce before the returning state evidence "capable of demonstrating that there are substantial grounds for believing" that, if removed, they would be exposed to a real risk of subjection to treatment contrary to article 3;
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> (b) in para 187 that, where such evidence was adduced in support of an application under article 3, it was for the returning state to "dispel any doubts raised by it"; to subject the alleged risk to close scrutiny; and to address reports of reputable organisations about treatment in the receiving state;
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> (c) in para 189 that the returning state had to "verify on a case-by-case basis" whether the care generally available in the receiving state was in practice sufficient to prevent the applicant's exposure to treatment contrary to article 3;
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> (d) in para 190 that the returning state also had to consider the accessibility of the treatment to the particular applicant, including by reference to its cost if any, to the existence of a family network and to its geographical location; and
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> (e) in para 191 that if, following examination of the relevant information, serious doubts continued to surround the impact of removal, the returning state had to obtain an individual assurance from the receiving state that appropriate treatment would be available and accessible to the applicant."

29. Recently in Savran v Denmark (Application No 57467/15) the Grand Chamber of the ECrtHR affirmed that Paposhvili provided a "*comprehensive standard*" in terms of mental illness as well, taking due account of all considerations relevant for the purposes of Article 3, and that it was for applicants to provide evidence capable of demonstrating that there are substantial grounds for believing that they would be exposed to a real risk of being subjected to treatment contrary to Article 3 (at [130] to [139]). It is only after this threshold has been met that the returning state's obligation to dispel any doubts which have been raised, and if necessary, seek assurances, comes in to play. At [14] the ECrtHR noted that,

> "whilst admittedly, schizophrenia is a serious mental illness, the court does not consider that that condition can in itself be regarded as sufficient to bring the applicant's complaint within the scope of Article 3".

30. The applicant in Savran was aware of his disease, acknowledged his need for therapy, and was cooperative, and there was no convincing evidence that the applicant had ever tried to harm himself ([142] to [144]).

31. I consider it appropriate the consider the 2nd ground of appeal first. Whilst the judge was clearly entitled to rely on the expert country report in his assessment of the general state of mental healthcare in Bangladesh, including reference to those with mental illness being neglected and stigmatised, there was no suggestion by the respondent in his personal evidence that this ever occurred to him, and it is clear that he sought and received treatment in Bangladesh. Indeed in his statement he claimed that he wanted to return to Bangladesh but was advised against this by his GP (I observe that there was no evidence from the GP in support of this particular assertion). The respondent claimed that he had limited contact with his family in Bangladesh and that his mother was elderly and unable to cope with his mental illness because she had "some serious disease" (again I observe that there was no evidence from the respondent's mother, or independent evidence of her age or state of health), but he never claimed to have been discriminated against or neglected because of his diagnosis in 2008. Dr Amundsen's report was based on the respondent's claim that he had no family to take care of him in Bangladesh, although the judge found that the respondent's mother was willing to provide him with, albeit, limited support because of her age. I pause merely to observe that, despite the respondent having been hospitalised and diagnosed with schizophrenia in Bangladesh in 2008, he nevertheless made various positive references to his family after this time. The letter from Dr John Iyiola, of the Newham East London NHS Trust Community Mental Health Team, dated 8 January 2012, indicated that the respondent had good communication with his family in Bangladesh. GP medical notes of 4 September 2012 indicated that he was in touch with his friends/family, and GP medical notes of 7 March 2013 also indicated that he was in touch with his family. The Consultant Psychiatrist letter of 15 August 2013 indicated that the respondent has family in Bangladesh and was in touch with them. Even after his episode in the UK in 2013 a Consultant Psychiatrist letter of 21 January 2015 indicated that the respondent was "getting on well with his family", and GP medical notes of 22 January 2019 indicated that one of the respondent's goals was to support his family in Bangladesh financially, again suggesting that he maintained a good relationship with his family.

32. Dr Amundsen referred to the level of public mental health care in Bangladesh being inadequate and hardly accessible, and that private healthcare was expensive (although he also stated that the cost of medication was relatively modest, a point not referred to by the judge), but this took no account of evidence that the respondent previously had access treatment in Bangladesh. Although the judge recorded the submissions made by the Presenting Officer that the respondent had received treatment in Bangladesh and that the medication (Risperidone) he was prescribed was the same he was using before he left Bangladesh, and that the medication was available in Bangladesh ([14], [41], [42] & [43]), and although the judge claimed to take account of that evidence [59], the decision does not make clear how the judge actually took this into account or how he reached his conclusion at [62] that the necessary treatment was not available in Bangladesh.

33. The Consultant Psychiatrist letter of 15 August 2013 indicated that the respondent was treated in hospital in Bangladesh. The letter from Dr John Iyiola stated that the Bangladeshi medical reports provided by the respondent indicated that he has been diagnosed with schizophrenia in Bangladesh and treated with Risperidone, Flupenthixol and Procyclodine. The respondent had therefore already received the same medication (Risperidone) that he received in the UK, and this medication was, according to the CPIN, available in Bangladesh. The information given to Ms Costa, to Dr Iyiola and the Consultant Psychiatrists indicated that the respondent had been hospitalised in Bangladesh, that he had been prescribed medication, that he, at least initially, was regularly seen at the hospital, and that he was advised to continue with his medication when he was preparing to come to the UK and was told to inform the health care professionals in the UK of his condition. The judge has not explained why this level of care would not be available to the respondent on his return to Bangladesh; nor is it clear that the judge has taken this into account in reaching his conclusion.

34. I note in addition that the judge found that the respondent had worked in the UK for several years in both the restaurant and construction industries (the medical notes indicated, in addition to work in a restaurant and construction, that the respondent had worked in a delivery business and a supermarket, and other medical documents indicate he worked for a newspaper doing survey work), and the evidence indicated that he is a college graduate in Bangladesh. It does not appear that any account had been given to the respondent’s work experience and to his ability to work and finance his treatment through his employment, despite his diagnosis of schizophrenia, in concluding that he would not be able to access medication or appropriate treatment in Bangladesh.

35. In respect of the first ground of appeal, the judge found that the respondent was not at risk of suicide. There was no challenge to this aspect of the judge's decision by way of a rule 24 response, or at the 'error of law' hearing. This aspect of the judge's decision was rationally open to him based on the evidence before him and the reasons given. As the respondent was not at risk of suicide, there must be some other element, or combination of elements, that would mean he would be subjected to 'intense suffering' if returned to Bangladesh. I am not however satisfied that the judge has adequately identified or explained what the substantial grounds were that meant that the respondent would face a real risk, on account of the lack of access to appropriate treatment in Bangladesh, of being exposed to a serious, rapid and irreversible decline in his state of health resulting in intense suffering. There is no explanation as to how the symptoms that the respondent would presumably experience in Bangladesh if he could not access medical treatment (hallucinations, paranoia, stress, low mood), in circumstances where he was <u>not</u> at risk of suicide, would result in a serious, rapid and irreversible decline in his state of health such as would result in intense suffering.

36. I am additionally concerned that the judge has not given clear reasons as to why the treatment the respondent received in Bangladesh following his diagnosis of schizophrenia in 2008 breached Article 3 ECHR. On the face of the totality of the evidence it is difficult to ascertain how the judge was entitled to reach this conclusion. The letter from Dr Iyiola refers to the respondent being hospitalised for a relatively short period of time in 2008 (seven to eight days), diagnosed with schizophrenia, and prescribed various low doses of anti-psychotic medication. According to the letter the respondent was asked to continue with his medication after being discharged, and a doctor of the National Health Institute in Bangladesh told the respondent when he was due to come to the UK that he (the respondent) would need to continue with his medication and that he should inform the health care professionals in the UK of his diagnosis. The account given by the respondent to Ms Costa describes the respondent being hospitalised in a small room (which the respondent described like a prison) for "ten to fifteen days" after he tried to jump from a moving car. He was prescribed medication, discharged, and then seen regularly at the hospital although the visits subsided. A second hospitalisation in 2009 occurred for two to three days (I note that the letter from Professor D Curtis dated 15 August 2013 describes the respondent being hospitalised on only one occasion in respect of two episodes in Bangladesh). The respondent claimed that he received "very old treatment" in Bangladesh and that the hospital was bad, but no other details were provided. The account given by the respondent of the treatment he received in Bangladesh comes nowhere close to establishing a breach of Article 3 ECHR on medical grounds.

37. I am satisfied for the reasons given above that the judge's decision involved the making of a material error on a point of law, and that the decision must be set aside. Both representatives invited me to remit the appeal back to the First-tier Tribunal for a de novo hearing were I to find a material error of law. Under the Tribunals, Courts and Enforcement Act 2007 the Upper Tribunal can either remake a decision of the First-tier Tribunal that involved the making of an error on a point of law, or it can remit the case to the First-tier Tribunal with directions for its reconsideration (s.12(2)). Under Part 3, paragraph 7.2(b) of the Upper Tribunal Practice Statement of the 18 June 2018 a case may be remitted to the First-tier Tribunal if the Upper Tribunal is satisfied that:

    (a) the effect of the error has been to deprive a party before the First-tier Tribunal of a fair hearing or other opportunity for that party's case to be put to and considered by the First-tier Tribunal; or

    (b) the nature or extent of any judicial fact finding which is necessary in order for the decision in the appeal to be re-made is such that, having regard to the overriding objective in rule 2, it is appropriate to remit the case to the First-tier Tribunal.

38. I found that the judge failed to take into account relevant considerations and that he failed to resolve conflicting evidence. Nor has there been any consideration of Article 8 ECHR in respect of the consequences of the respondent's return to Bangladesh. In these circumstances the Upper Tribunal considers it appropriate to remit the case back to the First-tier Tribunal for a full de novo hearing.

Notice of Decision

The decision of Judge of the First-tier Tribunal Roots contains an error on a point of law requiring it to be set aside.

The case will be remitted back to the First-tier Tribunal for a de novo hearing before a judge other than Judge of the First-tier Tribunal Roots.

Signed D.Blum Date: 02 February 2022

Upper Tribunal Judge Blum