Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: PA/01809/2020**

THE IMMIGRATION ACTS

Heard at Bradford	**Decision & Reasons Promulgated**
On the 23 February 2022	**On the 29 March 2022**

Before

UPPER TRIBUNAL JUDGE HANSON

Between

MUR
(Anonymity direction made)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Mr G Brown instructed by Parker Rhodes Hickmotts Solicitors
For the Respondent: Mr Diwnycz, a Senior Home Office Presenting Officer.

DECISION AND REASONS

Background

1. The appellant is a citizen of Bangladesh born on 25 October 1985.
2. The appellant entered the UK lawfully with a valid student Visa granted on 13 January 2011, which was extended by a further subsequent grant of post-study leave on 27 January 2012. A later

application for leave as an entrepreneur was refused with no right of appeal.

3. On 23 September 2014 the appellant claimed asylum which was refused on 6 March 2015. The appellant's appeal against that decision was refused by First-tier Tribunal Judge O'Hanlon in a decision promulgated on 18 May 2016.

4. On 23 October 2018, the appellant lodged further submissions which were refused by the Secretary of State on 10 February 2020. On 24 February 2020 the appellant lodged an appeal against that decision which was refused by another judge of the First-tier Tribunal. That decision was set aside resulting in the substantive re-hearing before the Upper Tribunal today.

5. The starting point for considering this matter is the determination of First-tier Tribunal Judge O'Hanlon in accordance with the Devaseelan principles.

6. In relation to the appellant's claim to have suffered torture at the hands of the RAB and the appellant's mental health issues, Judge O'Hanlon found at [38] of that determination that the medical evidence was "*limited*" noting "*letters recount what the Appellant had told the various medical practitioners in relation to having been tortured but none of them confirmed that the Appellants conditions are as a result of torture and I do not find that the medical evidence lends any significant weight to the credibility of the Appellants version of events*."

7. Judge O'Hanlon found at [47] that there was nothing in the evidence to indicate that without appropriate treatment the appellant poses a danger to himself or to others and that there was no significant basis for concluding the appellant's mental health issues were as significant as claimed.

8. Recent guidance has been provided on the correct approach to the Devaseelan principles by the Court of Appeal in Secretary of State for the Home Department v Patel [2022] EWCA Civ 36, in which reference was made to two earlier decisions of that Court in Ocampo v SSHD [2006] EWCA Civ 1276 (subsequently approved by the majority in AA (Somalia) v SSHD [2007] EWCA Civ 1040) and more recently in AL (Albania) v SSHD [2019] EWCA Civ 950.

9. William Davies LJ who gave the lead judgment in Patel, with whom the other members of the Court agreed, found that the submissions made by the Secretary of State's advocate in relation to the guiding principles arising from the earlier cases accurately reflect the approach in Ocampo and AL (Albania). Those submissions are set out at [37] of Patel in the following terms:

> 37. In her submissions in this appeal the SSHD submits that the guiding principles can be expressed as follows:
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> (i) Where there are different parties but with a material overlap of evidence, the *Devaseelan* principles of fairness apply with appropriate modification.
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> (ii) What fairness requires will depend on the particular facts of the case. The findings at an earlier FTT hearing will be an important starting point

but the second FTT judge cannot avoid the obligation to address the merits of the case on the evidence then available.

(iii) The second FTT judge necessarily will look for a very good reason to depart from the earlier findings. Whether the evidence could have been adduced at the previous hearing may be relevant to that issue. Equally, a very good reason may be that the new evidence is so cogent and compelling as to justify a different finding.

10. There is now available in this appeal a considerable amount of medical and country evidence that was not available to the earlier Tribunal and I find the principle of fairness requires a further consideration of the merits of the appellant's case in light of all the evidence now available. I find good reasons for departing from the earlier findings in that the new evidence is so cogent and compelling as to give rise to a real possibility of a different finding. There was no challenge to the additional evidence from the appellant being admitted by the Secretary of State prior to the hearing and in relation to a new piece of evidence provided to both advocates by the Upper Tribunal following my having judicial knowledge of a medical article which was of relevance to one aspect of the torture the appellant claimed to have suffered in Bangladesh and the resulting sequelae.

The medical evidence

11. The appellant relies on two main medical reports the first dated 30 June 2018 written by a Dr Anderson of Forrest Medico-Legal Services. There was no challenge before the Upper Tribunal to the suitability of Dr Anderson to write the report as an expert medical witnesses.

12. Dr Anderson sets out the background in some detail including the appellant's experiences within Bangladesh, the appellant's current medical history including an analysis of his mental health and the content of the GP medical records and medical records from the Immigration Reception Centre in which the appellant was held in 2015, and from the Bradford Royal Infirmary Department of Urology medical records. Dr Anderson provides an opinion in relation to the presentation of the appellant's physical problems between [145 – 155] and upon his mental health between [156 -166]. Drawing together her findings under the heading "overall picture" Dr Anderson writes:

> Overall Picture
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> 167. Paragraphs 188 and 267 of the Istanbul Protocol requires that the examining doctor assess the overall effects of the alleged torture on the individual.
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> 168. In my professional opinion the overall picture of MUR PTSD and depression, is highly consistent with his having been detained and ill treated in the way that he describes.
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> 169. In my professional opinion separate physical symptoms and signs are consistent with the account given. It is known that electricity can damage cell membranes and nerve tissue and can resulting in 'neuropathic pain'. It is also known that damage to internal structures may be greater than appears externally. Taken together - unitary problems, penile dysfunction leg pains and

lesion on foot - the whole scenario is highly consistent with MUR having been ill treated in the way that he describes.

13. In relation to the risk of suicidal risk and to others, Dr Anderson writes:

Overall Picture

167. I have considered whether MUR might be a risk to himself. He described thoughts of wanting to die, but reports no definite plan. I note his previous suicide attempts. In my opinion his risk of suicide is not known, but cannot be ruled out.

171. This risk should be reassessed if removal became imminent.

172. I have considered whether MUR is risk to others. I have seen no evidence of such risk.

14. It is Dr Anderson's opinion that the appellant's physical problems need further evaluation and treatment, that his ongoing PTSD and depression are distressing and detrimental to his present and future well-being with those conditions interfering with his normal functioning and with his integration into society, and that to aid his recovery he needs appropriate treatment including medication, social support, and access to psychological therapies.

15. The later report of Dr Wigley, dated 19 September 2020, took as its starting point the assessment of Dr Anderson which sets out the appellant's history, mental state and injuries in detail. The purpose of the second report was to enable an examination of the appellant's medical and psychological problems since Dr Anderson's report.

16. Dr Wigley sets out the appellant's current medical problems under separate headings of mental health, respiratory symptoms, genitourinary symptoms and leg pain, between [18 – 55], the appellant's mental state examination under the headings of appearance, behaviour, speech, mood, thoughts and perceptions, cognition and memory, insight, and physical observations between [56 -83]. There is then a detailed examination of the available medication taken by the appellant before Dr Wigley sets out her medical opinion in the following terms:

OPINION ON MENTAL HEALTH

91. MUR has significant mental health problems, impacting on his daily life. These difficulties have been documented in his medical notes over a number of years, as well as by Dr Anderson in her medico-legal report of 2018.

92. He has previously been seen by mental health specialists, but I do not have access to their records or letters. He is on a waiting list for treatment for his mental health problems which I believe may be for psychotherapy. The outcome of his specialist assessment and treatment may provide further information about his diagnosis and prognosis and the information in this report is, therefore to that extent, provisional. In the event that I am provided with further information I will consider whether an addendum to this report is necessary.

93. MUR described difficulty sleeping, nightmares, and intrusive memories of an acquaintance being murdered and his own ill-treatment in Bangladesh. These memories cause a significant level of distress and he tries to avoid thinking about them and sleeps with the light on, partly due to fears of nightmares. He described a change in his personality since being exposed to these traumatic events, manifesting in difficulty dealing with conflict and frightening situations, and sudden anger.

94. These symptoms are strongly suggestive of Post-Traumatic Stress Disorder (PTSD), and meet ICD – 10 criteria for these conditions.

95. MUR describes worsening of his PTSD symptoms, with increasingly vivid and distressing memories and nightmares, and this correlates with his presentation to me, including his detailed, almost visceral description of [K's] injuries.

96. He has severe anxiety which has been noted by his GP by respiratory physicians to contribute to his breathing difficulties. He has a strong focus on other physical symptoms, such as his urinary symptoms and leg pain, which may be a demonstration of somatisation (increased awareness of physical symptoms due to anxiety or other mental health problems). He describes a strong fear of dying from COVID-19 infection, his response to this suggests very high underlying levels of anxiety.

97. He denies psychotic symptoms and there was no evidence of psychosis during my assessment. However, some aspects of his presentation and review of his medical records raise concerns about an underlying predisposition to psychotic episodes. He describes episodes of visual hallucination (seeing a black cat, which he believes to be a bad omen rather than an image from his mind) and behaving abnormally (rocking and talking to himself, which came to the attention of people at his mosque).

98. His GP records show that he has previously described "7-8 episodes of violent hallucinations," and sought medical help for these, but later declined treatment having moved out of the house that he perceived to be haunted which resolved the problem. These episodes may represent psychological distress and anger alongside cultural or superstitious beliefs, or may be true psychotic episodes. When asked, he was unable to recall these episodes, and felt that the entry describing this history may have been a misunderstanding. While this is entirely possible it is also common for people who have experienced psychosis to be embarrassed, afraid of divulges the extent of their symptoms, lack recall into their psychotic episodes, or to be 'guarded' against confiding their experiences. It has not been possible for me to form a clear opinion on the aspect of MUR mental health given that I have no access to any medical evaluation or eyewitness account of his presentation during these episodes.

99. MUR describe low mood with previous episodes of self-harm and suicide attempts, but no suicidal ideas at the present time.

100. He describes frequent conflict with his housemates, which has got worse since the COVID-19 outbreak, due to an understandable fear of contracting COVID-19 as a result of his housemates failing to follow guidelines. During my interview with him he showed me a long list of crime report numbers from occasions when he has felt he had to call the police due to problems with his housemates. This may reflect the challenges of group living and anxiety around COVID-19, but he describes a long history of irritability and problems in relationships with others that predate the current pandemic. Irritability and anxiety, as well as suicidal ideas and self-harm, are common symptoms in

patients with Post Traumatic Stress Disorder. Both conditions are distressing, can affect day-to-day functioning, and increased risk of self-harm and suicide, and people with either condition can benefit from psychological treatment.

101. MUR's prognosis, from a mental health perspective, will depend in part on his social situation, levels of stress, social supports, and his ability to form a trusting relationship with a therapist for psychological treatment. A subjective sense of safety is important in the treatment of PTSD, and successful treatment may be difficult in the context of removal from the UK. Most people with PTSD have a good prognosis if they are able to pursue treatment in a safe, stable context.

102. MUR describes ongoing uncertainty about his immigration case, fear of removal to Bangladesh, and being unable to work or create a future for himself, as factors worsening his mental health, and impairing his recovery from trauma associated symptoms. This is clinically plausible, and fits with a recognition that occupation and a sense of subjective security are important prognostic factors in PTSD and mental illness in general.

SUICIDE RISK

103. Suicide risk is unpredictable and assessment of suicide risk is dependent on a dynamic assessment of the balance between risk factors and protective factors. Short and long-term risk of suicide are both important; short-term risk allows decisions on immediate care, and whether any safeguarding measures are needed, while long-term risk allows planning of care and highlights the importance of reassessing suicide risk in the event of potential triggering events.

104. MUR has a number of risk factors for suicide. He is a single male, socially isolated, and is experiencing physical health problems and high levels of stress. He is suffering from symptoms of depression and PTSD, has a potential psychotic illness, has a history of self-harm, exhibits difficulty with controlling his reaction to difficult events, as demonstrated by his irritability and difficulty coping with conflict, and has previously attempted suicide, including stepping in front of a bus, a 'violent' method which suggests a higher risk than, for example, an overdose. In my clinical opinion, in the long term, these factors place him at a moderate to high risk of self-harm and suicide.

105. To balance this there are currently a number of protective, or reassuring, factors. MUR denies suicidal ideas and takes comfort from the advice of his support worker, his faith, and the community at his mosque. Perhaps most importantly, he is able to describe some hope for the future, and his countenance visibly brightened when thinking about his "dreams" of working and forming a family.

106. In practice, in the short term, I would not regard MUR as being a high immediate risk of suicide and would not be involving emergency mental health services in his care. However, I would be aware of the potential for his suicide risk to escalate. Potential future triggers for self-harm and suicide include worsening of his mental health, acute psychosis, a negative change in his material circumstances, loss of social support, loss of faith, or a perception that his future is hopeless. Given his concerns about return to Bangladesh and his subjective fear of ill-treatment or murder there, I believe that his suicide risk is likely to increase if he returns to Bangladesh or perceives this to be an imminent prospect. I would recommend urgent reassessment of his mental state and suicide risk in these circumstances.

RISK ON RETURN

107. Whilst recognising that the objective determination of MUR future fears is not a matter for a clinician; it is acknowledged that lack of subjective safety also contributes to depression, anxiety, and trauma -related symptoms (van der Kolk 2000). It is recognised in working with survivors of abuse that a subjective fear (which appears to be genuinely held whether real or imagined) of further persecution tends to act as a 'stressor' and as a 're-traumatising' factor. I am concerned that if MUR is faced with removal to Bangladesh or he is removed there, then his subjective fear of being persecuted would be 're-traumatising' and could exasperate his depression and trauma related symptoms.

108. The availability and accessibility or otherwise of healthcare in Bangladesh is outside my field of expertise. I do not know if MUR would have access to treatment for his PTSD in Bangladesh.

109. However, it is recognised in working with trauma survivors that subjective fear of persecution is a strong re-traumatising factor. I am concerned that MUR's fear would be likely to exasperate his depression and trauma -related symptoms if he were returned to Bangladesh, and that even if he could access treatment, this would interfere with the effectiveness of any psychological treatment.

110. MUR's mental health problems are likely to make it difficult for him to live inconspicuously in the UK or any other country, and are likely to increase his vulnerability to harm from others, such as assault or arrest. He described episodes of unusual behaviour, was distressed and agitated at points during interview with me, and his GP records document an occasion when he became agitated and verbally aggressive. His difficulty in managing stressful or anxiety provoking situations without resorting to outside help is demonstrated by his reliance on his housing officers and a number of calls to the police as well as alleged assaults and harassment by his housemates.

OPINION ON RESPIRATORY DISEASE

111. MUR describes the severe symptoms from his COPD (Chronic obstructive pulmonary disease), and factors suggesting severe obstruction of his airways include his level of breathlessness, and his poor exercise tolerance.

112. It is difficult to separate MUR's known organic lung disease from his anxiety related breathlessness and, while MUR's lung function tests and the objective identification of wheeze during some of his exacerbations points to a physical cause for his breathlessness, it appears likely that his level of anxiety also makes him more breathless than his lung condition alone would do.

113. COPD is known to worsen over time, as patients get older, and as successive exacerbations cause damage to lung function. Over time, COPD often leads to progressive disability, or death. In smokers, loss of lung function and disability progress more quickly. COPD is unusual in patients as young as MUR, and his very young age at onset and the severity of his COPD suggest a poor prognosis.

114. Chest infections and exacerbations of his COPD would be expected to worsen his prognosis and should be treated promptly with antibiotics and steroids where needed. MUR is currently treated with moderate to high dose inhaled steroids, a treatment which is usually reserved for those with moderate to severe disease, and which can increase risk of pneumonia. His condition requires careful long-term management which will include regular inhaled therapies, treatment of exacerbations, monitoring of his lung function and

oxygen levels, and immunisation to prevent influenza and pneumococcal pneumonia.

115. If MUR is unable to access treatment for his COPD, for example, due to a subjective fear that doing so may place him at risk of detention, removal from the UK, or identification by the Bangladeshi authorities, his lung problems are likely to worsen, with a risk of severe illness or death due to exacerbation or chest infection. (An entry in MUR's medical notes from 2018, when he explained that he was frightened of "arrest" by the Home Office if he went to hospital, suggests this may be a factor in his ability to seek medical attention.)

116. Stopping smoking, exercise, and pulmonary rehabilitation can have a positive impact on the outcome in patients with COPD. While not curing the disease, these interventions could improve his prognosis and slowdown deterioration in his lung function.

117. MUR's future mental health is likely to have a bearing on his breathing difficulties and the severity of his COPD. He reports that, due to his current mental health problems, he has not been able to stop smoking and his GP and respiratory clinic records document that he has expressed this difficulty on numerous occasions. While there is no guarantee of successful smoking cessation, and MUR's own motivation and belief in his ability to stop will play an important role, it is my professional opinion that any improvement in MUR's mental health and stress levels could increase his chances of successfully stopping smoking.

118. Furthermore, MUR's doctors have repeatedly noted that anxiety symptoms contributes to his breathlessness, and drive a pattern of dysfunctional breathing. Anxiety is commonly noted to worsen symptoms of lung disease, while experiencing breathlessness can reinforce anxiety, resulting in a 'vicious circle' of increasing distress and reduced activity levels. It is likely that treatment for MUR's mental health reduction in his anxiety levels which reduces breathlessness and allow him to approve his exercise levels and lung function.

119. Respiratory conditions can have an impact on fitness to fly due to reduced circulating oxygen levels. MUR's reports that he is currently able to walk about 50 m and has normal oxygen levels on pulse oximetry. Civil Aviation Authority guidance states that he would be expected to tolerate air travel well. However, the guidance recommends further assessment and consideration of supplementary oxygen for patients who experience severe breathlessness on walking less than 50 metres at a normal pace. It MUR's COPD and exercise tolerance worsened in the future, as may be expected given the natural history of the disease, he is likely to need formal respiratory of his fitness to fly.

…

CLINICAL PLAUSIBILITY

123. I am aware the guidance of the Upper Tribunal in *JL (medical reports – credibility) China [2013] UKUT 00145 (IAC)* and note that it is not for me as a clinician to come to any conclusion regarding MUR's credibility. However, I note that it is expected that I perform 'a critical and objective analysis of the injuries and/or symptoms displayed.' (headnote 3, *JL (medical reports – credibility) China)).* I confirm that I have done so. I note paragraph 35 of the reasons for refusal letter refers to *SSHD v AE & Anor Sri Lanka [2002] UKIAT 05237* which states that "doctors generally accept the account given by the patient unless there are good reasons for doing so". This would appear to

contradict the requirement to be 'critical' made in JL China. I confirm that (by reference to paragraph 37 of the reasons for refusal letter) my opinions are not "entirely based on the account given" by MUR.

124. I thus interviewed MUR using open, non-leading questions, and explored symptoms in further detail where necessary. I compared his account to other evidence before me, in the form of his medical records and Dr Anderson's previous medico-legal report. Where there were discrepancies in his account, I questioned him on these. I have considered the possibility that MUR is feigning or exaggerating his symptoms.

125. I note that MUR's history of witnessing a traumatic murder, his own ill-treatment, and resulting mental health problems and urinary symptoms have been described on multiple occasions in his medical notes over a period of several years. His symptoms have led him to seeking medical help, including specialist referrals, over this time and his degree of distress and anxiety has been consistently noted by clinicians from both primary and secondary care, even when he attended for help with his respiratory problems and the focus was on treatment for his lung disease.

126. I am aware that MUR's account of ill-treatment was not disclosed when he initially sought help for his Peyronie's disease from his GP and that he gave a different (and clinically implausible) explanation for the condition and that he did not mention it at his initial asylum interview. In clinical terms delayed disclosure in cases of trauma is well recognised, particularly when the nature of trauma is highly personal or sexual.

127. It is also noted that MUR attempted to 'play down' or deny certain symptoms when asked about them directly, rather than take the opportunity to exaggerate or report more severe symptoms. In particular, he denied suicidal ideas, and denied psychotic symptoms. He also appeared to play down some aspects of his illness, and did not volunteer his difficulties with anger and irritability. Rather, he described his conflict with others more in relation to the COVID-19 pandemic and their behaviours, rather than his own mental illness, until I further explore the issue and challenged him on the subject.

17. The appellant had asserted that he had been tortured by the Rapid Action Battalion (RAB) in Bangladesh as a result of his having witnessed their murdering a friend of his and what he describes as suspicion for the reason why he had been in India.

18. In his witness statement of 10 March 2020 the appellant writes:

6. I am unable to return to Bangladesh for two reasons. The first is that I am wanted by RAB. I believe that if I were to return I would be killed by this dangerous government group straight away.

7. I am also unable to receive medical treatment for my problems, I suffer from life changing issues. I have a wound on my left ankle due to electric torture I suffered from RAB. I also have great difficulty in passing urine. This again was due to the electric shocks I received. I also suffer from post-traumatic stress disorder (PTSD) anxiety due to what I witnessed.

19. It was not made out that if the appellant was returned to Bangladesh he would be of adverse interest to the authorities. On the appellant's own account, after he was questioned by the RAB, which included his being tortured, he was released. It is not made out he has an adverse

profile that would bring him to the attention of the authorities in Bangladesh or that will create a real risk of persecution or ill-treatment on return. The lump the appellant has on his left foot, which he tributes to electric shock, was not thought to result from such ill-treatment by Dr Anderson or Dr Wigley, but that does not mean the appellant was not tortured in the manner he claims to have been.

20. The difficulty in this case is, notwithstanding there been no objective risk to the appellant on return from the RAB he clearly, subjectively, believed he faces a real risk. This is a contributing factor to the question of whether he would seek treatment, if it was available, and the issue of re-traumatisation.

21. The additional, a report admitted on the day of the hearing is entitled 'Parrilla urethra: a sequalae of electric shock torture to genitals in men.' The appellant's case was that those inflicting torture upon him inserted wires into his penis which he describes as causing the most excruciating pain and which it is accepted by the clinicians who wrote the report could be responsible for a number of the problems. These mirror those the appellant is experiencing in his genital area.

22. The author of the report notes that *"Since the 20th century, electric shock torture has become one of the most prevalent methods of torture partly because it produces sequelae that are more challenging to visibly detect, particularly when administered using high voltage and low current. In sexual torture, a wire is wrapped around the head of the penis and a wire electrode is inserted into the urethra. This produces unbearable pain and can lead to urethral strictures with devastating physical and psychological consequences."*

23. The medical evidence notes urethral stricture and erectile dysfunction in the appellant which the report shows can be caused by electric torture similar to the type described by the appellant.

24. It was accepted that I can place weight upon the report which has been prepared by doctors who undertook a study with 40 patients who attended the Department of Urology, Directorate of Health Services, Srinagar, Kashmir in India between March 2010 and November 2014. The results of the study showed that most of the urethral strictures were located in the same area, that some degree of erectile dysfunction was present in 100% of the patients, that psychological sequelae including depression, anxiety, acute stress disorder and symptoms of post-traumatic stress disorder were observed. Such conditions both in relation to physical and mental health are those reported as being present in the appellant in the medical reports.

25. I find, considering the evidence as a whole, that the appellant was ill treated in Bangladesh, including having been tortured by the method he describes, by the RAB and accept his account of his experiences in Bangladesh to be credible.

The country evidence

26. It is relevant at this stage to examine the country evidence regarding the availability of the medical services the appellant will require if he was returned to Bangladesh.

27. An updated bundle prepared by the appellant for the purposes of the hearing containing updated material relating to the provision of medical services within Bangladesh has been read.

28. Within those documents is the Secretary of States CPIN dated 7 May 2019. Which in relation to mental health services states:

> 9. Mental health
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> 9.1.1 An Australian DFAT report of February 2018 noted, 'Despite considerable needs, there are few support services available for those suffering from mental health disorders and [there is] no specific mental health authority in Bangladesh.' [58] The US State Department 2018 Report on Human Rights Practices similarly observed, 'Government facilities for treating persons with mental disabilities were inadequate [for the country as a whole].' [59]
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> 9.1.2 MedCOI commented in a response of 4 September 2015: 'Based on the information found in several sources, mental illness in Bangladesh is highly stigmatized and mental healthcare is in its nascent stages. Healthcare provision is limited ... However, steps for change and improvement are taken. 'Mental healthcare is offered by both government and private facilities, the vast majority being concentrated in urban areas, especially in metropolitan cities [...] Most psychiatrists work in tertiary care in urban areas. They also work either in private practice or in a mixture of teaching and private practice in cities. 'Healthcare at primary level is provided by healthcare centres (PHC) where a physician can be found and [at] PHC clinics with no physicians. 'According to [a WHO report of 2007], all or almost all physician-based clinics (81-100%) have assessment and treatment protocols for key mental health conditions available, in comparison to only a few clinics (1-20%) in non-physician based primary health care centers. 'Due to the dearth of mental health professionals and poor logistic support, the existing three tier health care delivery system is not functioning well for mental health conditions. Referrals of patient with mental disorders to mental health specialists by the general practitioners or other health care providers are almost non-existent. [Referrals are] also hampered due to superstitious beliefs related to psychiatric disorders. 'The Bangladesh Health System Review counts 50 outpatient mental health facilities, 31 community-based psychiatric inpatient units and 11 community residential facilities. Schizophrenia is the most common condition treated in outpatient centers.' [60]
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> 9.1.3 The National Institute of Mental Health & Research (NIMH), in Dhaka, is a 200-bed teaching hospital which, according to MedCOI, offers free or low- cost psychiatric care on an inpatient or outpatient basis [61]. Professional services include adult and child psychiatry, psychotherapy and clinical psychology, drug addiction and rehabilitation [62].
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> 9.1.4 The Department of Psychiatry at Bangabandhu Sheikh Mujib Medical University (BSMMU), a public hospital, provides inpatient or outpatient treatment by a psychiatrist and inpatient or outpatient treatment by a psychologist [63].
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> 9.1.5 MedCOI found in September 2017 that these treatment options were available for PTSD and a depressive disorder: - Inpatient or outpatient treatment and follow up by a psychiatrist - outpatient treatment and follow up by a psychologist - treatment of PTSD by means of EMDR - treatment by means of psychotherapy: e.g. cognitive behavioural therapy - treatment of PTSD by means of narrative exposure therapy. [64]
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> 9.1.6 An article in the journal European Psychiatry noted in 2015 that: '[A] wing of child psychiatry has [been] established in Bangabandhu Sheikh Mujib Medical University (BSMMU) and separate department named "Child Adolescent and

Family Psychiatry" has [been] formed in National Institute of Mental Health (NIMH), Dhaka. [The] Center for Neurodevelopment and Autism in Children (CNAC) [was] also established in BSMMU with the mission to serve the children with neurodevelopmental disabilities, to increase awareness and to train... professionals.' [65]

10.1.6 A broad range of medicines for psychiatric treatment are obtainable. To check the availability of a particular generic drug, its brand names and the pharmaceutical company which supplies it in Bangladesh, refer to BDdrugs.com: Central nervous system drugs [66].

10.1.7 According to an Australian DFAT report of February 2018, 'Considerable social stigma attaches to reporting mental illness.' [67]

29. The material provided by the appellant speaks of genuine attempts by the authorities in Bangladesh to try and improve or reform health services but a chronic shortage of the resources being made available to enable them to do so.

30. If the appellant is returned to Bangladesh there is a real risk, as identified by the medical professionals, of re-traumatisation. Within the safe environment of the UK the appellant has already tried to kill himself and the risk of suicide if the appellant perceives he is going to return to Bangladesh and steps are taken to return him is clearly set out in the medical evidence.

31. As noted above, there is also the additional factor in this case, that even if some medical services were available in Bangladesh the appellant will be unlikely to approach the authorities for help as a result of a subjective fear of being discovered, arrested and tortured by the RAB. I accept that that this is a real subjective fear, as identified in the medical evidence. If the appellants physical and mental health deteriorates by being returned and he does not receive adequate treatment he will face a real risk of suicide and deterioration in his physical health particularly in relation to his lung disease.

32. It is not made out the appellant will have family support or assistance on return or a network that would assist in being able to overcome any fears he has to access appropriate medical services.

33. It is not made out that the counterbalancing factors that mitigate against the appellant committing suicide in the UK, which are identified as providing a safety net for him, would be available in Bangladesh.

Discussion

34. The key issue in this appeal relates to the physical and mental health of the appellant especially in light of the realistic prospect of re-traumatisation should he be returned to Bangladesh.

35. The correct test to be applied in medical cases is that set out by the Supreme Court in AM (Zimbabwe) v. Secretary of State for the Home Department [2020] UKSC 17 of there being 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’ Paposhvili v.

Belgium (Application No. 41738/10) (13 December 2016) [2017] Imm. A.R. 867.

36. In this appeal there is a combination of absence of appropriate treatment to meet this appellant's particular mental health and physical needs combined with the lack of access to such treatment as a result of his subjective fear of making himself known to the authorities in Bangladesh and the limitation of the mental health facilities available in that country. I do not find that the subjective fear to be an irrational fear in light of the ill-treatment, including torture, that he suffered in the past.

37. The reference to a significant reduction in life expectancy means 'substantial'. I accept that if the reduction in the appellant's life was not substantial then it would not attain the minimum level of severity required to engage article 3, based upon the judgement in AM (Zimbabwe) v. Secretary of State for the Home Department [2020] UKSC 17. I find in this appeal that that threshold has been shown to be crossed.

38. I accept in relation to the issue of suicide there is a high threshold consider the judgement of the Court of Appeal in J v Secretary of State for the Home Department [2005] EWCA Civ 629 (24 May 2005). In this appeal it is the inadequate psychiatric care on return which has not been shown to be sufficient to deal with the appellant's complex needs, which will give rise to a real risk of his committing suicide as identified in the medical evidence. Whilst the NHS within the United Kingdom should be able to manage any risk if they are aware of the same, it is not always the case that they will be aware, and it is not made out that if the appellant was returned to Bangladesh, he will be able to obtain to psychiatric care he requires to deal with both his PTSD, psychosis, and other identified conditions.

39. I find the appellant has established that if he is removed to Bangladesh there is a real risk of a breach of article 3 to the standard and threshold which apply. In light of this the burden passes to the Secretary of State who will be precluded from removing the appellant unless she is able to provide evidence countering the appellant's evidence or dispelling doubts arising from that evidence' see AXB (Art 3 health: obligations; suicide) Jamaica [2019] UKUT 397 (IAC) (15 November 2019).

40. In this appeal Mr Diwncyz had insufficient evidence available to enable him to discharge that burden. In reality, all he was able to refer to was the CPIN referred to above which he realistically accepted in fact strengthen the appellant's case in light of the medical evidence.

41. As Mr Diwnycz observed the evidence that is now available had somewhat overtaken the content of the Secretary of State's refusal letter.

42. Having considered all the material with the required degree of anxious scrutiny I find the appellant has established on the basis of his medical condition that to remove him from the United Kingdom would give rise to a significant reduction in life expectancy arising form to a serious, rapid and irreversible decline in his state of health resulting in intense

suffering or to a significant reduction in life expectancy and even death as a result of his medical needs or successful suicide.

Decision

43. I allow the appeal.

Anonymity.

44. The First-tier Tribunal made an order pursuant to rule 45(4)(i) of the Asylum and Immigration Tribunal (Procedure) Rules 2005.

I make such order pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008.

Signed……
Upper Tribunal Judge Hanson

Dated 25 February 2022