Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: IA/34321/2013

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On 10th April 2017	**On 12th May 2017**

Before

UPPER TRIBUNAL JUDGE FRANCES

Between

[B A]
~~(ANONYMITY DIRECTION NOT MADE)~~

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr D Furner, instructed by Birnberg Peirce & Partners Solicitors
For the Respondent: Mr Tarlow, Home Office Presenting Officer

DECISION AND REASONS

1. The Appellant is a citizen of Nigeria born on 26th February 1980. His appeal against a refusal to vary leave was allowed by First-tier Tribunal Judge Abebrese on Article 8 grounds on 23rd May 2016.

2. The Appellant's case before the First-tier Tribunal was argued under Article 3 on the basis that the Appellant's mental health would deteriorate upon return, leaving him at an increased risk of suicide, and applying J v Secretary of State for the Home Department [2005] EWCA Civ 629, the appeal should be allowed. Alternatively, on return to Nigeria it was reasonably likely the Appellant would require compulsory admission and treatment. This treatment would breach Article 3. The judge accepted that the Appellant was suffering from a severe and enduring mental illness and that he would be at high risk of relapse.

3. The Appellant sought permission to appeal against the Article 3 findings only, asserting that the First-tier Tribunal had erred by
   (1) identifying the incorrect legal test;
   (2) applying that incorrect test to the facts of this case in a way which materially affected the outcome;
   (3) specifically the First-tier Tribunal failed to determine the arguments made to it that removal would breach Article 3 of the European Convention of Human Rights because of the heightened risk of suicide and because of the conditions of return, neither of which mandated the D test.

4. Permission was granted by First-tier Tribunal Judge Page, on 30th September 2016, on the grounds that it was arguable the judge had materially erred in law in his consideration of the Appellant's medical condition under Article 3. It was arguable that the judge applied an exceptionality threshold, he did not properly apply the relevant case law and he failed to take into account the six factors set out in J v SSHD.

5. In her Rule 24 response, dated 27th October 2016, the Respondent did not oppose the Appellant's application for permission to appeal and invited the Tribunal to determine the appeal and consider whether the Appellant succeeded under Article 3. The Secretary of State intended to argue at the remaking of the appeal that the Article 3 element still ought to be dismissed.

6. The matter came before Deputy Upper Tribunal Judge Peart on 14th November 2016. He found that the judge had erred in law for the reasons given by the Appellant and agreed by the Respondent. The matter was listed for an oral hearing in order to reassess Article 3. There was no challenge to the First-tier Tribunal judge's Article 8 findings or his factual findings. Therefore the issue in this appeal is whether the Appellant would be at risk of Article 3 treatment if returned to Nigeria today.

The hearing

7. Mr Furner for the Appellant relied on five bundles of documents. A1 and A2 were before the First-tier Tribunal and contained the Appellant's two witness statements. A1 contained a lot of evidence in relation to the Appellant's Article 8 claim, which is not relevant to this appeal. A2 contained medical evidence and background material.

A3 comprised 152 pages and contained the expert evidence; three reports of Dr Bell and the Appellant's medical records. A4 was a bundle of background material of 116 pages and A5 was an authorities bundle.

8. Mr Furner relied on his skeleton argument dated 6th April 2017, the referenced chronology, which was before the First-tier Tribunal, and an Amnesty International Report dated 3rd April 2017. The Appellant was called to give evidence confirming his name and address, and relying on his statements of 27th May 2015 and 11th March 2016 as his evidence-in-chief.

9. In cross-examination, the Appellant confirmed that he was fit and well. He had been mentally unwell in the past and that had been treated. He was still under mental health care, but he had moved into the care of his GP with whom he had prime contact. He was feeling a lot better and was taking his medication regularly, two in the morning and two at night. He had now stopped taking Prozac. He was taking his medication on his own and his GP had made a comment on how he was likely to progress; he would remain stable. That is what the Appellant depended on now.

10. The Appellant was asked to comment on the Respondent's view that he could return to Nigeria. He stated that he did not have anyone there. His father had died and his mother's family had not wanted her to marry his father and therefore she was left on her own, but she too had now died. There was treatment and medical care in Nigeria but it was difficult to access. The Appellant stated that anyone behaving like him would end up on the streets. There was no such mental health treatment in Nigeria. He was still seeing his partner and children in Manchester and he had last seen them three weeks ago when he stayed for two weeks.

Submissions

11. Mr Tarlow relied on the refusal letter dated 7th August 2013 and submitted that the Appellant had been unwell in the past but he had received treatment. Mr Tarlow referred me to Dr Bell's third statement at page 34 of A3, paragraph 24:

> "[BA] continues to suffer from psychiatric disorder. Currently, his condition is reasonably stable however he will need continuing careful management and should be regularly reviewed by the appropriate psychiatrist service, perhaps once every three months. In between the psychiatric reviews he can continue to be managed by his general practitioner with whom you has a good relationship. It needs to be understood that the core of good psychiatric management rests on the establishment of secure enduring trusting relationships with the relevant medical personnel and the fact that this has been established here suggest that as long as this context is not disturbed he is likely [to] remain stable for a while and also be able to alert the relevant personnel if he senses his state is deteriorating."

12. Mr Tarlow also relied on paragraphs 10, 14, 17 and 22 in which Dr Bell states:

> "10. The mental health team are no longer involved but he knows how to contact them in a crisis."
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> "14. His appetite is good, he cooks rice and eggs for himself as he has little money but enjoys his food when he visits his family, his weight is steady."
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> "17. [BA] was not obviously severely depressed or manic. I learnt however that he sometimes cries. These episodes are precipitated by his deep regret that he cannot provide support for his children. He wants to work and be a provider for his family. There is no evidence of suicidal ideation and he feels life is worth living. He believes that he will be able to remain in the UK in light of the outcome of the most recent Tribunal and that is doubtless a positive factor which tends to promote the stability of his condition and protect against deterioration."
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> "22. [BA] remains a Christian and is a member of the Christian Apostolic Church. He only goes to church on Sundays and meets some acquaintances there. He is not close to them and they worship together. He knows the pastor but not well. He believes God is helping him."

13. I pointed out paragraph 25 to Mr Tarlow which states:

> "He is highly likely to suffer a deterioration in his condition from time to time as this is the natural course of the disorder. The most important factor in terms of predicting breakdown deterioration would be the appearance of any major external stressor. This type of psychiatric disorder is very likely sensitive to such stresses. One of the most significant stresses in this regard would arise if there is any alteration or disruption to his current social context including any action to remove him from the country."

14. Mr Tarlow submitted that the Appellant's condition was cyclical; the Appellant gets better and worse but his condition is treatable. It is clear from the earlier reports that he was less well then, than he is now. Mr Tarlow submitted that treatment is available in Nigeria, although it may not be as easily accessible as in the UK. He relied on GS and EO v Secretary of State for the Home Department [2015] EWCA Civ 40 and submitted that there was a very high threshold in relation to Article 3 health cases and this had still not been met by the Appellant.

15. Mr Furner submitted that there was a high threshold in health cases and in Article 3 suicide cases, which was apparent from the case of J v SSHD. However, there was a second argument, namely that on return the Appellant would be subject to serious harm. The threshold was a reasonable degree of likelihood: NO (Afghanistan) v Secretary of State for the Home Department [2016] EWCA Civ 876.

16. Mr Furner submitted that the Appellant was in a period of stability at the moment. However, the referenced chronology showed that the Appellant was first arrested in March 2010 and detained under immigration powers in April 2010. He was sectioned in June 2010 and transferred to hospital in July 2010. An entry in his medical records in October 2010 indicated that the Appellant's case was one of the worst cases his treating clinician had ever seen. The Appellant was released on temporary admission on 20th October 2010 his condition was stable on medication. He remained stable for some time.

17. On 17th April 2014, the Appellant's condition was assessed as stable. However, on 30th April 2014 the Appellant was sectioned for a second time. He was arrested by the police on 29th April 2014 after acting in an extremely disturbed and unpredictable manner in the area outside his flat. He was running around holding a cable and shouting in an aggressive manner. Care records confirmed that it took ten staff members to administer tranquilisers given the Appellant's disturbed state. He became so agitated and starting punching the walls and the door, stripped naked and urinated on the floor and then started to smear the urine on the wall and on his back. He was then committed for compulsory psychiatric inpatient treatment for a period of six months.

18. Mr Furner submitted that there had been a period of stability for three and a half years after the first section, but within a period of twelve days (17th to 29th April), because of the upcoming appeal, the Appellant had a breakdown with no warning. The Appellant was discharged on 4th September 2014 but was again sectioned on 27th September 2014 when he was arrested after knocking on a neighbour's door while naked. He was discharged on 20th November 2014 and thereafter his appeal was allowed. The chronology was important because it showed that it was not possible to infer that any period of stability would last.

19. Mr Furner referred me to Dr Bell's first report in A3 of the Appellant's bundle, at paragraphs 46 and 47 which state:

> "46. When I saw [BA] in 2013 he also appeared reasonably stable. However he showed clear features of disorder, particularly some disorganisation of his thinking, tangentiality and over expansiveness which are all typical of Bipolar Disorder in the more hypomanic phase (that is manic features which are not severe enough to warrant a diagnosis of full blown mania) - Bipolar Disorder being the diagnosis at that time given to him by his treating clinicians. He was receiving a regime of psychotropic medication which appeared to be keeping things reasonably stable.
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> 47. It is clear however from the more recent records that [BA] has to be kept under psychiatric supervision and that this should be kept up indefinitely given

> the high likelihood of relapse especially when he is under severe stress. It is likely that the psychiatric services will make use of the facilities of Assertive Outreach and the home treatment team. Periods of apparent stability should not be confused with a condition which is in remission as is demonstrated in the records for [BA]. Periods of stability can be followed quickly and without warning by a precipitate and potentially life threatening episodes of psychosis. These are most likely to be brought on by changes in his environment."

20. Mr Furner relied on Dr Bell's report, at paragraph 52, that the Appellant "is a vulnerable individual who will be susceptible to relapses and such relapses are likely to be caused by major external stresses. If he receives leave to remain this will remove a potent stressor and is likely to be an important factor in stabilising his condition. I consider however that he is likely to remain vulnerable to relapse, even in the UK and without the threat of removal, for the rest of his life."

21. The Appellant required involuntary admission on several occasions in the past and is very likely to require this again in the future (paragraph 66) and at paragraph 67:

> "It is clear from the records I have seen and to a degree from my own observations of [BA] that he can present in an objectively bizarre and aggressive fashion when he is seriously unwell. I am concerned that his behaviour while unwell would be likely to draw hostile attention in an environment where ignorance and stigma about mental illness are prevalent and certainly if [BA] was confronted with hostility and stigma I would be concerned that this could trigger a further deterioration in his condition."

22. Mr Furner then referred to the third report of Dr Bell at page 31 of A3 at paragraph 25. He submitted that this encapsulated the situation. This evidence established that the Appellant would be at risk of a psychotic breakdown on return to Nigeria. This may not be immediate but was likely. The Appellant was likely to need involuntary treatment. In fact, in Dr Bell's opinion, it was very likely this would be the case. It was clear from the medical records how the Appellant behaves when he goes through one of these episodes. He is aggressive, loud, he goes out in public, takes off his clothes and spreads bodily fluids. He would be likely to come to the attention of the police in that state. When this happens in the United Kingdom the Appellant is sectioned. The question is what would happen if he returned to Nigeria.

23. Mr Furner referred to page 37 of bundle A4, the Country Report on Human Rights Practices for 2016, United States Department of State which states: "Mental healthcare services were almost non-existent. Officials at the small number of prisons used private donations to provide separate mental health facilities for prisoners with mental disabilities. All prisoners with disabilities stayed with the general inmate population and received no specialized services or accommodations."

24. Mr Furner referred to the Lunacy Act 1958 which was in effect the applicable Mental Health Act in Nigeria. A report entitled Mental Health Legislation and Involuntary Commitment in Nigeria, Call for Reform by Andrew Hudson Westbrook published in the Washington University Global Studies Law Review, volume 10, issue 2 (at page 78 of A4) states:

> "Many families that find their relatives' mental health issues too difficult or expensive to handle at home simply pass the responsibility to the prisons creating a class of persons known as civil lunatics. Instead of obtaining treatment at hospitals or mental health institutions these civil lunatics are jailed in asylums within prisons generally receiving no treatment. The current law in Nigeria allows any building to house an asylum and contains no requirement for treatment of inmates."

25. Mr Furner relied on the Amnesty International Report, 3rd April 2017, and submitted that the conditions in asylum facilities were appalling and the examples given in the report showed that civil lunatics were chained to the railings and left. There were no human rights monitoring and no appeal provisions. The Lunacy Act did not limit the duration of detention when the full procedural process is followed. Under the Lunacy Act 1958 there were no provisions for the length of detention, consent or appeal.

26. Mr Furner relied on paragraph 77 of the Amnesty International Report which refers to the Westbrook Report and states: "Westbrook goes on to emphasise the lack of any provisions in the 1958 Act pertaining to treatment of people subject to involuntary confinement, as a particularly remarkable feature of the legislation. It should also be noted though that the legislation also lacks any appeal provisions against decisions made under it or any consideration of issues around consent to treatment."

27. Mr Furner submitted that the assessment of the Appellant started at paragraph 69 of the Amnesty International Report. Paragraphs 17 to 81 were particularly relevant and, on the basis of what is stated therein, Mr Furner submitted that what could happen in theory under the Lunacy Act did not happen in practice. A person was often compulsorily detained and then the procedures were complied with later. At paragraph 81 of the Amnesty International Report it states:

> "While the procedural elements authorising involuntary committal set out above continue to be used their application is not universal. The procedures have been reported to us have been both complex and longwinded and as a result subject to corruption and inefficiency. To the extent that they are used, it is frequently only retroactively once committal has taken place for some time. The likelihood of the procedures being used is reportedly increased substantially by the presence of family members who are initiating the

committal or when the committal followed arrest by the police and the officers followed formal procedure."

28. Mr Furner submitted that, should the Appellant come to the attention of the police because of his behaviour, he would be held in prison. It was possible that he could be held in a mental health hospital and he referred me to paragraph 89 of the Amnesty International Report which states:

> "As with healthcare generally in Nigeria mental healthcare and drug treatment is provided at the patient's cost. In practice this is most often borne by the family of the patient. Estimates provided to Amnesty International by an experienced Nigerian psychiatrist interviewed for this report were that admission would cost around N100,000 while diagnosis and medication would cost a further N50 - 100,000."

29. Mr Furner submitted that the minimum wage was N18,000 and therefore admission itself was five times the minimum monthly wage. What was overwhelmingly likely to happen in the Appellant's case was that on return his condition would deteriorate and he would require treatment under the Lunacy Act or arbitrarily outside it. Dr Bell was of the opinion that it was very likely that he would require compulsory treatment. The Appellant's condition was characterised as remission and relapse even in the UK. The Appellant would need compulsory treatment at some point in the UK in the future. The current psychiatric picture was false. This was a hypothetical issue if the Appellant is returned today. Psychiatric evidence shows that the Appellant knows he can remain in the UK as his appeal has been allowed. His fear had therefore gone, but if he was returned his current stability was not a guide to resilience, there had been three and a half years before the most recent breakdown.

30. The conditions in which the Appellant would be detained in Nigeria would breach Article 3. There was an absence of monitoring, an absence of appeal rights, an absence of treatment and the Appellant had no family to assist him. His return to Nigeria would result in serious harm and a breach of Article 3. This case was not about the inability of the state to provide treatment, it was about the treatment under Nigerian statute which would actively result in a breach of Article 3 and the threshold was a reasonable degree of likelihood. There was no need to look at the adequacy of treatment because the positive treatment by the Nigerian authorities would result in Article 3 harm. The facts of the case of NO (Afghanistan) were similar to this one and Mr Furner invited me to allow the appeal on Article 3 grounds.

Findings and conclusions

31. The Appellant is 37 years old and he has a partner and three children in the UK. His partner is pregnant with their fourth child. Her immigration appeal was allowed by

the Upper Tribunal on trafficking grounds and she is awaiting a grant of leave from the Respondent. The judge concluded that it would not be proportionate or reasonable to expect the Appellant's family to leave the country with him. The Applicant would be returned to Nigeria alone.

32. The Appellant has been diagnosed with either schizophrenia or schizoaffective psychosis and he required compulsory admission and treatment under the Mental Health Act on three occasions while in the UK; most recently on 27th September 2014. The medical evidence demonstrates that the Appellant has been diagnosed to have serious medical and mental health illness for which he has had treatment over a number of years. The Appellant's condition is such that even after long periods of stability he can still have a breakdown and suffer a period of psychosis without any warning. The trigger factors appear to be external stresses and changes in environment.

33. The Appellant is suffering from a severe and enduring mental illness and he would be at high risk of relapse. If this were to happen then his self-care and safety would also be put at risk. If the Appellant is removed to Nigeria there would be grave and severe consequence as a result of that removal.

34. The Appellant has been in the UK since 2007 and has not returned to Nigeria during that time. He would be returned to Nigeria without any family support and, whilst he is currently stable in the UK and able to administer his own medication, a change in environment could trigger a psychotic episode and could result in the Appellant becoming loud and aggressive and bringing himself to the attention of the authorities. If that were to occur it is likely that he would be arrested and detained under the Lunacy Act 1958.

35. The Amnesty International Report states in conclusion:

> "119. We consider that the Appellant would face a series of risks as a result of his serious mental illness if he were to be returned to Nigeria. Our assessment of risk is based on the expert medical evidence regarding the severity of his condition and the likelihood of a substantial decline in his mental stability probably resulting in a mental health crisis. It is also based on his known history of behaviour when experiencing such a crisis.
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> 120. If the Appellant were to be returned alone that is without being accompanied and assisted by his family we consider that the single most likely risk to him will be abandonment and street homelessness. This is because there is little or no outreach infrastructure to monitor and support people suffering from serious mental health illness outside of family support and little or no broader social infrastructure in terms of supported or even subsidised housing. Moreover while we do not doubt that in such a scenario the Appellant's UK resident family would wish to continue to assist the Appellant, we have taken into account the expert medical evidence which suggests that when unwell and

deteriorating towards crisis the Appellant would struggle to maintain contact with his support network and would otherwise struggle to engage in self-beneficial behaviour. As such homelessness would inevitably carry with it the well-known risk of rights abuse that are associated with such a situation including vulnerability to abuse, exploitation and violence. It appears likely that these risks will be increased if the Appellant were experiencing a serious deterioration in his mental state given the strength of the prevailing social stigma and lack of understanding regarding mental illness. Appropriate medical experts would be able to comment on what effect street homelessness in Lagos conditions would have on the Appellant's psychiatric condition and his physical health more broadly.

121. Secondly we consider that the Appellant would face a real risk of adverse contact with the Nigerian police. The risk would arise immediately upon arrival at the airport if, as per medical advice, the Appellant found the process of forced removal sufficiently distressing to induce a serious relapse in his condition. There would be an ongoing risk of such adverse contact on the streets of Lagos especially in the event of such a relapse. In this regard we also note that the Appellant has a history of behaving aggressively towards others including police officers when unwell. A factor which we consider exacerbates the risk adverse contact with the Nigerian police would in turn carry with it the real risk firstly of indefinite detention under the Lunacy Act 1958 or on an arbitrary basis outside of that legal framework and secondly of serious physical mistreatment by police officers. While there is evidence of police officers delivering seriously mentally ill individuals to the emergency unit at Lagos Psychiatric Hospital, the incidents of this occurring are proportionality very small. It therefore appears more likely that the detention by police officers would result in the Appellant either being held in police cells or in the prison estate. Conditions in these instances are notably extremely poor and in some instances life threatening. Given their known history of conduct and institutional culture as well as the Appellant's particular behaviours and vulnerabilities we consider that the Appellant's arrest by the Nigerian police will carry with it at least a real risk of mistreatment sufficiently serious to constitute torture and/or inhumane treatment."

36. On the basis of the factual findings, the opinion in the Amnesty International Report and the opinion of Dr Bell, the Appellant is likely to suffer a breakdown at some point on return to Nigeria whether that be at the airport or some time later. He is likely to come to the attention of the police if he has such a breakdown and he would not be able to access the psychiatric hospital in Lagos because he is unable to afford treatment there. Accordingly, it is likely that he would be held in prison where the conditions for this particular Appellant with his particular condition would result in treatment in breach of Article 3. I find that Mr Furner has established the second limb of his argument.

37. In relation to the Article 3 suicide risk Mr Furner did not make any submissions before me although the matter was covered in his skeleton argument. The relevant test is that set out in J v SSHD [2005] EWCA Civ 629 in which the Court of Appeal gave the following guidance:

> "26. First the test requires an assessment to be made of the severity of the treatment which it is said that the Appellant would suffer if removed. The ill treatment must necessarily be serious such that it is an affront to the fundamental humanitarian principles to remove an individual to a country where he is at risk of serious ill treatment.
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> 27. Secondly a causal link must be shown to exist between the act or threatened act of removal or expulsion and the inhumane treatment relied on as violating the applicant's Article 3 rights."
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> 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 inhumane 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.
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> 29. Fourthly an Article 3 claim can in principle succeed in a suicide case.
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> 30. Fifthly in deciding whether there is a real risk of breach of Article 3 in a suicide case the 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 removal will be in breach of Article 3.
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> 31. Sixthly a further question of considerable relevance is whether the removing and/or 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.

38. The submissions in the skeleton argument are that the Appellant's removal would entail a heightened risk of suicide and, although he cannot show that he is objectively at risk, his subjective fear is real and overwhelming. Moreover while there is plainly some mental health treatment available in Nigeria, it would neither be effective to reduce the risk nor practically accessible to the Appellant. It is submitted that the Appellant passes the high test set out in J v SSHD and his appeal should be allowed on Article 3 grounds.

39. In relation to the fourth factor in J v SSHD it was submitted that, although the Appellant was not currently suicidal, in the context of the deterioration which inevitably would occur if the Appellant returned to Nigeria, there would be an

increased risk of suicide and acts of self-harm. Dr Bell considered that even if the Appellant did not actively commit suicide he would be likely to eventually succumb to inanition or death through self-neglect. Dr Bell indicated that a return to Nigeria would be very likely to precipitate a relapse and that the Appellant's current stability was very likely to be because he does not perceive himself as being imminently at risk of removal. However learning of an imminent removal would be a major traumatic event sufficient itself to cause relapse.

40. It was submitted, in terms of the fifth factor, that the Appellant could not show an objective risk of ill treatment. However, the courts had established that a real subjective fear may be of equal importance and that the absence of an objective risk may be of little or no relevance if the condition is characterised by fundamental distortion of thinking and perception.

41. Dr Bell comments at paragraph 50 (page 13 of A3) that: "I have noted above that [BA]'s condition appears to be particularly sensitive to his environmental situation. In my view the fact that [BA] is under threat of return to Nigeria acts as a major stressor which is likely to be having a serious detrimental effect upon his mental state and may be preventing some degree of recovery. I believe that [BA] is subjectively very frightened about being returned to Nigeria - but this is for reasons I have not been able to fully understand and which I cannot objectively assess. I am satisfied that this fear is real to him and this fear of return is an important contributory factor to his mental state. I note in particular that his dramatic deterioration in the early part of 2014 leading to being sectioned in April 2014 was specifically linked by his treating clinicians to the then approaching immigration appeal. That seems entirely plausible to me, and consistent with what I would expect based upon my interviews with him."

42. At paragraph 60, Dr Bell states: "In my judgment the Appellant would not be able to cooperate with local psychiatric services for the reasons given more fully below that is because I believe [BA] would upon return deteriorate so severely that he would be unable to maintain relationships even with his own family were they to follow him and would likely succumb to serious self-neglect and eventual inanition."

43. It was submitted that the Appellant essentially has no prospect of accessing mental health treatment. If the Appellant returned to Nigeria he is reasonably likely to deteriorate to such a state that he will either actively commit suicide or kill himself through self-regret. It was submitted that in those conditions his removal would be in breach of Article 3.

44. It is accepted that the Appellant cannot show an objective risk of ill treatment. The medical evidence indicates that the Appellant would not be at risk of suicide on return, rather that he would be at risk of killing himself through self-neglect. I find that the Appellant's behaviour is such that he is likely to come to the attention of the authorities and therefore he would be unlikely to die through self-neglect and inanition.

45. I am of the view that the Appellant, even on the evidence of Dr Bell, has failed to show that his fear of ill treatment in the receiving state upon which the risk of suicide is said to be based is objectively well founded. The threshold test under J v SSHD is particularly high and the Appellant's Article 3 suicide claim fails in that respect.

Summary

46. The Applicant would not be at risk of Article 3 treatment because of a heightened risk of suicide. He would, however, be at risk of inhuman and degrading treatment in breach of Article 3 because of the conditions of return.

47. The medical evidence indicates that the Appellant is vulnerable to relapse even in the UK and without the threat of removal. His removal to Nigeria is likely to trigger a relapse and his behaviour will draw hostile attention. His treatment by the authorities in detaining him under the Lunacy Act 1958 would amount to inhuman and degrading treatment. There is a reasonable degree of likelihood that he would be detained in a prison, there would be no treatment for his mental health, his situation would deteriorate, the length of detention is indeterminate, there is no right of appeal and there is no requirement for him to consent to treatment. Accordingly, I allow the Appellant's appeal on Article 3 grounds.

Notice of decision

The Appellant's appeal is allowed on Article 3 grounds.

No anonymity direction is made.

J Frances

Signed Date: 11th May 2017

Upper Tribunal Judge Frances

TO THE RESPONDENT
FEE AWARD

As I have allowed the appeal, I have considered making a fee award and have decided to make a fee award of any fee which has been paid or may be payable.

Signed *J Frances* Date: 11th May 2017

Upper Tribunal Judge Frances