Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: PA/01112/2020

THE IMMIGRATION ACTS

Decision & Reasons Promulgated
On the 14 August 2023

Before
UPPER TRIBUNAL JUDGE O'CALLAGHAN
UPPER TRIBUNAL JUDGE NORTON-TAYLOR

Between

CE (CAMEROON)
(ANONYMITY DIRECTION MADE)

Appellant

-and-

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Heard at Field House on 16 January 2023

Representation:
For the Appellant: Ms E Gunn, Counsel, instructed by Duncan Lewis & Co
For the Respondent: Ms A Ahmed, Senior Presenting Officer

A daughter of the appellant enjoys lifetime anonymity in relation to criminal proceedings: sections 1 and 2(1)(aa) of the Sexual Offences (Amendment) Act 1992.

Pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008, the appellant, his former wife and their children are granted anonymity. No-one shall publish or reveal any information, including the name or address of the appellant, likely to lead members of the public to identify the appellant, his former wife and their children without that individual's express consent.

Failure to comply with this order could amount to a contempt of court.

DECISION AND REASONS

Introduction

1. The appellant is a national of Cameroon who was sentenced at Portsmouth Crown Court on 31 January 2011 to a total of eighteen (18) years' imprisonment, having been found guilty by a jury in respect of four counts of raping a child aged under 13 and two counts of assault female child under 13 – penetration of vagina/anus with part of body/object.

2. The victim was his daughter, aged between six and nine at relevant times. The offences took place in the family home between April 2005 and April 2009.

3. The appellant continues to deny his guilt, stating that his former wife brainwashed their daughter and coached her as to the allegations made.

4. The respondent seeks to deport the appellant, a foreign national criminal, considering him to have committed a particularly serious crime and to constitute a danger to the community.

5. The appellant resists deportation, asserting that his return to Cameroon would breach rights protected by article 3 of the European Convention on Human Rights, incorporated domestically by the Human Rights Act 1998.

6. For the reasons detailed below we dismiss the appellant's appeal.

Previous judicial consideration

7. By a decision dated 27 May 2021, the First-tier Tribunal (Judge of the First-tier Tribunal Smeaton) upheld a 'section 72 certificate' issued by the respondent, the appellant having been convicted by a final judgment of a particularly serious crime and found to be a danger to the community in this country: section 72 of the Nationality, Immigration and Asylum Act 2002, at [61]-[63].

8. The First-tier Tribunal concluded that the appellant would face treatment contrary to articles 2 and 3 ECHR if returned to the anglophone Northwest/Southwest ('NWSW') regions of Cameroon consequent to his personal characteristics, at [108]-[121].

9. By a decision dated 28 March 2022 this panel of the Upper Tribunal preserved the findings detailed at [7] and [8] above. The rest of the First-tier Tribunal decision was set aside, with the resumed hearing to be heard by this Tribunal. The appellant was directed to file any further documents he wished to rely upon no later than 21 days before the resumed hearing.

10. A panel hearing was listed on 4 October 2022.

11. At 17.31 on 3 October 2022, after the close of business, Duncan Lewis Solicitors, the appellant's legal representatives, filed with the Upper Tribunal an addendum report written by Dr Charlotte Walker-Said, dated the same day. No prior indication had been provided by Duncan Lewis Solicitors as to there being an expectation of delay in securing expert evidence, nor was any request made for an adjournment prior to the hearing. Ms Gunn declared herself ready to proceed on the morning of the hearing, in circumstances where neither the respondent, the respondent's representative nor the panel had enjoyed the opportunity to consider the report. The panel members did not receive the report until approximately 1pm on the day of the hearing.

12. We consider the approach adopted by the legal representatives was unfortunate, and not one sufficiently focused upon their duties to help the Upper Tribunal to further the overriding objective, and to cooperate with the Upper Tribunal generally: rule 2 of the Tribunal Procedure (Upper Tribunal) Rules 2008.

13. In the interests of fairness, the hearing was adjourned and relisted on 16 January 2022.

Issues before the Upper Tribunal

14. The parties agreed that the following issues were before the panel:

    i) Article 3 ECHR, in respect of mental health: does the appellant face a breach of protected rights on return to Cameroon on account of his mental health?

    ii) Article 3 ECHR, in respect of internal relocation: will the appellant face a breach of protected rights upon return to Cameroon?

15. Amongst various documents, the appellant relies upon reports from:

    i) Dr Nuwan Galappathie, Consultant Forensic Psychiatrist at the Huntercombe Centre, Birmingham.

    ii) Dr Charlotte Walker-Said, Assistant Professor of History, Department of Africana Studies, John Jay College of Criminal Justice, City University of New York.

16. Additionally, the appellant filed and served medical records covering the period from June 2017 to May 2022. They cover his time in prison, his subsequent detention under the Immigration Act 1971 (where he remained in the prison estate) and recent engagement with his GP surgery. These medical documents are referred below as 'GP records'.

17. We have been provided with the appellant's OASys, dated 14 May 2020. It was agreed by the representatives that the Offender Assessment System tool records various information provided by the appellant to both HM Prison and HM Probation Services over time.

Anonymity Order

18. By our decision of 28 March 2022, we issued an anonymity order. We observed that there was a clear public interest in the identification of the appellant who has been convicted of very serious sexual offences. However, we noted section 1 of the Sexual Offences (Amendment) Act 1992 which prohibits the reporting of any matter which may lead to the identification of a complainant in respect of certain sexual offences, including rape: section 2(1)(aa) of the 1992 Act. We concluded that if the appellant were not subject to an anonymity order, his unusual last name would quickly lead to the identification of his daughter and such identification would result in the loss of protection provided to her by the 1992 Act.

19. In the circumstances, we are satisfied that the daughter's protected rights under article 8 ECHR outweigh the public interest protected by article 10 ECHR.

20. The anonymity order is confirmed above.

Vulnerable Witness Application

21. Ms Gunn requested that the panel treat the appellant as a vulnerable witness on account of his mental health. Reliance was placed upon the medical opinion of Dr Galappathie detailed in a psychiatric report dated 7 December 2020 and addendum reports dated 12 February 2021 and 22 July 2022.

22. The appellant was offered a break every 30 minutes during his evidence and permitted to take a break when a request was made.

Background

23. The appellant is a national of Cameroon and is presently aged 50. He hails from Ekona, situated in the South-West Region of Cameroon.

24. He states that his younger half-sister resides in Hampshire, and his two brothers reside in the United States of America.

25. An entry in his GP reports dated 9 May 2017 records the appellant informing prison healthcare as to his mother having twelve (12) children.

Entry into the United Kingdom

26. The appellant secured entry clearance as a student in 1999. He studied nursing at an English university.

27. He secured indefinite leave to remain in 2009 and last returned to Cameroon in that year.

Family in the United Kingdom

28. The three living children of the appellant and his former wife are adults and British citizens. A fourth child died in a choking accident when aged six.

Family in Cameroon

29. The appellant acknowledges having had several extra-marital relationships, both in the United Kingdom and in Cameroon. He details the relationships as being long-term, in the region of two to three years, and that he usually remained friends with his partners. He states that he only started to have affairs when his wife falsely accused him of being unfaithful.

30. He has a child from his relationship with QN. Their son was born in 2007 and at the date of hearing he was aged 15. Mother and son reside in Cameroon.

31. The appellant has provided various and inconsistent details as to the length and nature of his relationship with QN. At one extreme he informed his offender supervisor that 'this relationship has been going on for over 20 years', at the other extreme he stated in his evidence before the panel that his relationship with QN was a short one commencing in 2006 and continuing for a period thereafter.

32. He informed his offender supervisor that he was in telephone contact with QN every fortnight whilst in prison. In a witness statement, dated 23 May 2022, he stated that whilst in prison he spoke to her once every couple of months.

33. His offender supervisor was also informed that QN was 'totally aware' of his circumstances in the United Kingdom and that he 'had planned on leaving his wife for his partner in the Cameroon once the children were in secondary school.'

Employment

34. He worked in a hospital in this country for several years. In his report dated 7 December 2020, Dr Galappathie records the appellant informing him that during his nursing career he provided treatment to numerous victims of serious road traffic accidents and other traumas which he has at times found distressing.

35. The appellant enlisted as nurse with the Royal Air Force on 18 August 2004. During his service he was engaged in overseas operations in Iraq for some six months.

Criminal convictions

36. The appellant has two convictions for drink driving, and additionally convictions for failing to provide a specimen of breath, assaulting a police officer, driving without insurance and driving whilst disqualified.

Post-discharge employment

37. Following an earlier conviction, the appellant was discharged from HM Forces on 19 February 2009.

38. He worked for a nursing agency prior to his arrest in relation to the index offence.

Index offence

39. After a five-day trial, the appellant was convicted at Portsmouth Crown Court on four counts of rape of a child under thirteen years old and two counts of sexual assault by penetration of a child.

40. In January 2011, HHJ Henry sentenced the appellant to four concurrent eighteen-year custodial sentences on each count of rape of a child and two concurrent five-year custodial sentences in respect of the counts of sexual assault.

41. HHJ Henry remarked, *inter alia*:

> "[The victim] was young and vulnerable. I am satisfied that she did not in fact consent to what you were doing. You were aware of the power your held over her. You sought to persuade her by using sweets and the promise of money. These offences were committed repeatedly over a lengthy period of time. It is clear from her evidence that you ejaculated. For a child now of eleven to have to give evidence of what happened when she was much younger, and to give a graphic description of seeing gooey stuff on the end of your penis, is persuasive of the fact that you ejaculated in her presence.
>
> As her natural father this was the breach of the ultimate degree of trust. You were a person that a small child should have been able to look to for protection, for help and for guidance. Instead, what she got from you was abuse for your own sexual gratification.
>
> ...

> These are very serious offences that were committed over a period of time …
>
> The Sentencing Guidelines Council have identified starting points and ranges for offences of rape. And it seems to me that looking at the ranges this falls within the top bracket of offences. It is repeated rape of the same victim over a course of time … In this case, as I have already indicated, I have come to the conclusion that there was a gross abuse of trust and that you ejaculated. Those are both aggravating factors.
>
> … Taking account of aggravating features and the age of your daughter at the time, I have come to the conclusion that the appropriate starting point in your case is one of 18 years imprisonment … I cannot, of course, give you any credit for a plea of guilty because you fought these charges, and you forced your daughter to come and give evidence.
>
> In respect of the sexual assault matters … it was all part and parcel of the rape offences. But you have been convicted of two counts, multiple incident counts, in relation to this. There will be concurrent sentences of five years imprisonment in relation to those two charges."

42. The appellant contends that his daughter fell off her bike and it was believed that she had broken her leg. He ran out to find her and carried her home. He could tell that her leg was not broken. He placed her on the living room sofa and obtained ice from the fridge. As her trousers were too tight, he removed them, but left her underwear on. He placed ice on her leg and gave her paracetamol. He told his son to look after his sister, and proceeded to contact his then wife who was angry that he had not taken their daughter to A&E. She said that she would come home from shopping and take their daughter to A&E. The appellant then went to sleep, and in the meantime his wife returned home and took all the children away by car. The next thing he recalled was the door opening and five police officers arresting him, accusing him of sexually abusing his daughter.

43. Following his conviction, the appellant was placed on the sex offender register for life. He was subsequently struck off the Nursing and Midwifery Council register in December 2011.

44. The appellant continues to deny his guilt, detailing that he never touched his daughter, and she is lying. He has previously stated that his former wife put their daughter up to making the allegations and coached her as to what to say. He asserts that his former wife brainwashed their daughter.

Healthcare in custody

45. By his December 2020 report, Dr Galappathie records:

> ‘26. [The appellant] told me that he has experienced a significant amount of trauma and witnessed numerous traumatic events. He told me that when deployed to Iraq he was stationed within a hospital setting and provided treatment for numerous people that had suffered from serious injuries. He said that many people had severe injuries from explosions including colleagues who worked within artillery, gunners, and those within bomb disposal. [The appellant] told me that several people who he knew well had suffered serious injuries. [The appellant] said that he has also witnesses several people being ‘blown up’ in front of him including colleagues that he has known well. He said that his ‘classmate’ Blake who worked as a logistics driver was killed by an improvised explosive device.’

46. The appellant informed Dr Galappathie in 2020 that he had not had contact with mental health services prior to his conviction in 2011.

Deportation proceedings

47. The respondent issued a notice of liability for deportation in November 2017. A deportation order was issued on 24 July 2018 and the appellant’s human rights claim was refused by means of a decision dated 25 July 2018.

48. The appellant subsequently claimed asylum in June 2019 relying upon the ‘Anglophone Crisis’, also known as the ‘Ambazonia War’, which is part of a long-standing dispute between the central government of Cameroon and the Anglophone territories of the NWSW regions. These regions were formerly controlled by the United Kingdom under a United Nations mandate and joined the former French colony of Cameroon in 1961. Since the 1980s, President Paul Biya has conducted an ‘assimilation’ process directed towards the Anglophone regions of Cameroon. The Cameroon government’s position is that the step of assimilation is to be undertaken to affirm the country’s political maturity and to demonstrate that the people have overcome their language and cultural barriers.

49. In the meantime, the appellant completed the custodial element of his sentence in August 2019 and was subsequently placed in immigration detention. He was released on bail in October 2020.

50. The respondent refused the appellant’s asylum and human rights claim by a decision dated 21 January 2020, with an attendant certification of the asylum claim under section 72 of the 2022 Act.

Healthcare after release

51. Following his release into the community, the appellant completed a ‘new patient health questionnaire for adults’ when registering with a GP surgery. In respect of any serious illnesses and the year they took place, he detailed: depression 2011, hypertension 2015 and poor sight 1995.

52. By the summer of 2021 the appellant was suspected of suffering from obstructive sleep apnoea. He was reporting his sleep as not being refreshing despite having around seven hours of sleep when waking up at 4am. A sleep study was carried out on 15 July 2021, and established that the appellant has moderately severe sleep disordered breathing with an apnoea hypopnoea index of twenty-two events an hour.

First-tier Tribunal

53. By its decision the First-tier Tribunal concluded that the appellant had not rebutted the statutory presumption and upheld the section 72 certificate observing, *inter alia*:

    i. The appellant was convicted of an extremely serious crime;

    ii. He has not admitted responsibility; and

    iii. He poses a high risk of serious harm to children.

54. The First-tier Tribunal found that the appellant would be able to pass through the airport and onto his home area safely.

55. However, the First-tier Tribunal concluded as to the circumstances in the Anglophone NWSW regions, the appellant's home area, that there was a real risk of ill-treatment simply by virtue of an Anglophone individual being exposed to violence on return consequent to the general situation as it existed.

56. Alternatively, the First-tier Tribunal concluded that the appellant would be at real risk in the NWSW regions because of his actual or imputed political opinion, at [116]:

> '116. For the same reasons, I find that the Appellant would be at real risk on return to his home area because of his actual or imputed political opinion.'

57. No additional reasoning was provided.

58. In respect of a second alternative, the First-tier Tribunal found that the appellant would be at particular risk because of the general situation of violence and insecurity in the NWSW regions, reasoning, *inter alia,* that the appellant would seek to work as a nurse upon return to Cameroon, and by working as a nurse, he would be at real risk of treatment breaching article 2 and 3 ECHR from both separatist forces and the authorities because the evidence demonstrates that medical staff working in the NWSW regions are at particular risk. When working in those centres, medical staff have come under attack from both the State, which accuses them of supporting

the separatists, and non-State armed groups, which accuse them of supporting the government.

59. The findings as to risk in the NWSW regions were not challenged by the respondent before the Upper Tribunal.

Evidence

60. The appellant adopted his witness statements dated 23 March 2020, 11 February 2021 and 23 May 2022. He made two amendments to his 2021 witness statement, which were noted by the panel.

61. In examination-in-chief, the appellant confirmed that he only served in Iraq and not in Afghanistan as detailed at various times to persons in prison and additionally in his 2021 witness statement. The latter was said to have been written in error.

62. He continues to take Sertraline, an anti-depressant medication, once a day.

63. As to possible inconsistency between his asylum interview and a subsequent witness statement as to whether he knew of any living relatives in Cameroon, the appellant explained that in his interview he was referring to ‘uncles’ and ‘aunts’ who were tribal relatives. He has no blood relatives in Cameroon.

64. He explained that he last had contact with QN in 2016 when she was living in Limbe, in the South-West region. He was not permitted to talk to her about their son during phone calls in prison because of restrictions imposed by HM Prison Service. He tried to contact her a couple of times in 2017 but could not get through by telephone, so removed her number from the list of numbers permitted for him to use by HM Prison Service because there was a limit imposed on accessible numbers.

65. The appellant accepted that his United Kingdom resident sister had not provided a witness statement in support, but this was because she had not been asked to by his solicitors and if she had been asked, she would have provided one.

66. As to his educational history in Cameroon, he secured his senior year examinations and then attended university in the national capital, Yaounde, for a year in 1992, where the medium of teaching was the French language. He left after a year and secured employment as a primary school teacher in a village, Muea, close to the city of Buea, situated in the South-West region. The children were taught in French and English. He taught at the school for a year before securing at place at the University of Potsdam, Germany, where he studied English literature and German for four years. Having obtained his degree, he secured entry clearance to the United Kingdom as a student nurse.

67. Ms Gunn turned her questions towards the GP records. The appellant confirmed that he went on hunger strike twice whilst in prison. The prison authorities were aware on both occasions. The first time for three days, when he came to the end of his custodial sentence in 2018 and remained in detention. He stated that he was depressed and stressed. The second occasion was for five days as he had sought asylum in writing and the respondent had not come back to him for some three or four months. He identified his hunger strike as being the spark that led to the respondent accepting that he had made a claim. He confirmed that the second hunger strike was commenced before 20 June 2019.

68. The appellant confirmed that on each occasion, as he was not going to get food, prison officers would attend his cell and ask what he was doing, and why. Food would be brought to his cell, and he would refuse it.

69. In respect of an identified entry on his GP records in December 2020 detailing that he was suicidal, had attempted suicide, and had self-harm thoughts, the appellant explained that frustration had built up around the failure to secure his release from prison at the conclusion of his custodial sentence, and he expressed taking his own life because it was a thought of his to do it.

70. In cross-examination, the appellant denied knowing where QN resided in Cameroon. He denied that he was not truthful as to the nature and extent of his relationship with QN. He explained that he knew her in High School, and subsequently they had no contact whilst he was in Europe, until he returned to Cameroon on holiday in 2006. They had a child, and subsequently spoke on the telephone. He accepted previously stating that it was not a close relationship but thought the reference to closeness equated to proximity. He accepted that whilst in prison he had stated his intention was to return to Cameroon and live with QN. He applied for early release from prison so that he could go back to Cameroon with the expectation that QN could help him resettle.

71. He denied contacting his offender manager in 2022 to seek to change an entry relating to QN on OASys because he believed the original entry may affect his appeal.

72. He denied having siblings in Cameroon. He stated that he only had three siblings, one of whom was a half-sibling living in Hampshire. He was directed to his GP records which detail him confirming that his polygamous father had four wives and twenty-one children. The appellant stated that his father had two wives, with the other two wives being the former wives of dead uncles. He explained that levirate marriages were traditional. His mother had two children, and his stepmother had one. The remaining eighteen children were cousins, born to his uncles. He accepted he could have been clearer when discussing this matter, but it was tradition.

73. The appellant did not know if any of his relatives, including his cousins, were still residing in Cameroon. He denied having contact with them. He lost contact with them all when he travelled to Europe. His senior brother in the United States communicates with the family, and it is this brother deals with them about matters.

74. Ms Ahmed took the appellant to a reference in one of Dr Galappathie's reports where he confirmed that he had received bad news about his uncle from home. The appellant detailed that he was referring to a member of his tribe, and he was informed about the death by his senior brother in the United States. It is his senior brother who informs him as to what is happening with distant relations.

75. When asked why he was upset at hearing news of his uncle's death if he was simply a member of the tribe, the appellant detailed, "When I was growing up, I knew him. He was helpful to the family. I was sad and upset."

76. He explained that both of his parents are from the Mbo tribe, and it is a cultural norm to consider all members of the tribe as relatives. However, all the members of his tribe are poor, and he does not have contact with them, so he cannot secure support from them if he returned to Cameroon. He added, "I don't know where they are".

77. Addressing his GP records, the appellant confirmed that he attended a doctor in prison to express his distress and was placed on medication. He accepted that he was able to discuss his health problems without embarrassment, though it took a while to approach healthcare. He accepted that both the GP records and OASys confirmed that he only wanted to be around veterans and Christians in respect of his mental health concerns, and that he had regularly stated that he would not act on suicidal thoughts. He addressed the latter before us by stating that it depended upon what was going on in his head.

78. In respect of his assertion in his 2022 witness statement that he considered his current risk of suicide to be very high "especially when I contemplate being deported to Cameroon", the appellant explained that he did not address previous assertions in his medical reports that he would not commit suicide because of his religious beliefs as his solicitor did not ask him about this. He stated that he did have an intention to hurt himself, because one does not know what will happen tomorrow.

79. The appellant accepted that he had not sought healthcare support or medication for the first four or five years in prison. He could not recall the first time he raised concern as to PTSD. Ms Ahmed drew the appellant's attention to an entry in the GP records on 31 March 2017 when he referenced for the first-time having flashbacks for either four, five or eight years. A subsequent entry on 6 April 2017 confirmed the appellant informing a nurse that his PTSD was more visible when he had not slept well. The nurse noted that the appellant had not had a formal diagnosis for

PTSD. The appellant stated in response to Ms Ahmed's questioning that he was helped by healthcare for a while, but he experienced trauma at times.

80. Following his release from prison, he engaged in psychological therapy with PTSD Veteran Resolution by attending seven counselling sessions between January and March 2022.

81. He was taken to the entry on the GP records dated 9 May 2017 where he presented in a 'jovial mood' when describing himself at the "devil incarnate" at night, and that "I cannot kill myself, but I can kill another person." He denied being in a jovial mood. He stated that he was in a bad mood.

82. He explained that in various prisons he engaged with veterans' support for PTSD

83. He confirmed that he was placed on the vulnerable wing at every prison, and in a single cell until he was transferred to HMP Brixton early in 2017. When asked if he relied upon having PTSD to secure a single cell at HMP Brixton, he stated that he could not remember. He was asked by Ms Ahmed as to whether he was acting in a manipulative way by asserting that he had PTSD to secure a single cell. He replied, "I found it very difficult to sleep without light and a radio. My cell mate was not happy. I struggled to sleep.' When asked why he said that he could kill someone, he replied, "I was very depressed and wanted to be on my own, to process what was in my head."

84. As to whether he informed Dr Galappathie about his sleep apnoea, the appellant stated that he could not remember. He detailed that Dr. Galappathie should have read his patient records, and that normally he would say that he had this issue.

85. In respect of informing Dr Galappathie that he heard voices in his head, the appellant said that he believed he had raised it when attending A&E in respect of chest pains, and with his GP. Upon reflection, the appellant confirmed that he had not raised it at A&E or with his GP. He possibly informed his therapist. It was possible that he only informed Dr Galappathie.

86. He explained that he was not content to discuss flashbacks and nightmares with his GP because he had spoken to a veteran and thought discussing with a therapist was sufficient. He told his GP that his medication was not working and that he wanted to change it.

87. When asked why he had not referenced suffering from PTSD, nightmares and flashbacks when engaging with the sleep clinic, the appellant stated that he spoke to professionals on their own issues. He had flagged these issues up previously, and that his GP records detail what he suffers from.

He then stated that he had forgotten to mention to the sleep clinic that he had PTSD.

88. The appellant was taken to an entry on his GP records confirming that on 23 September 2020 he was discharged by the healthcare team at HMP Maidstone as not suitable for the Inreach caseload at the present time. He stated that he could not remember being discharged.

Discussion

89. We take the opportunity to thank both representatives for their considered oral submissions. We further wish to indicate our thanks to Ms Gunn for her carefully drafted, and very helpful, skeleton argument dated 30 September 2022. We confirm that we have noted and considered the representatives' oral submissions with care.

90. We further confirm that we have considered all documents relied upon by the parties as well as the appellant's oral evidence before us.

91. The parties were informed at the hearing that we would take judicial note of relevant prison policies and guidance.

Article 3 - Mental Health

92. The first question we are required to consider is whether the appellant faces a breach of his protected article 3 rights upon return to Cameroon on account of his mental health.

93. Ms Gunn submitted that relying upon the test set out in *AM (Zimbabwe) v. Secretary of State for the Home Department* [2020] UKSC 17, [2021] AC 633, there is a real risk that removing the appellant to Cameroon will result in a 'serious, rapid and irreversible decline' to his mental health, resulting in intense suffering and/or a substantial reduction in life expectancy. Reliance is placed upon the medical opinion of Dr Galappathie that the appellant continues to suffer from a severe episode of depression, generalised anxiety disorder and PTSD. Since February 2022, the appellant has been prescribed an anti-depressant, Sertraline, with a daily dosage of 100mgs per day. He was previously taking Paroxetine.

94. We observe the guidance provided by the reported decision of *AM (Art.3; health cases) Zimbabwe* [2022] UKUT 00131 (IAC).

95. As to his inability to secure appropriate medication and health treatment upon return to Cameroon, the appellant relies upon reports prepared by Dr Walker-Said.

96. Having carefully considered the evidence of Dr Galappathie, we conclude for the reasons detailed below that no weight can be given to his opinion

as to the appellant's mental health because he has failed to expressly or implicitly engage with medical opinion provided by the healthcare team treating the appellant for a significant period of time in prison, and has provided no reasoning as to why his opinion differs from the GP records. As the Upper Tribunal noted in *HA (expert evidence; mental health) Sri Lanka* [2022] UKUT 00111 (IAC), at [161], a tribunal is unlikely to be satisfied by a psychiatrist's report which merely attempts to brush aside GP records.

97. Additionally, having undertaken a holistic assessment of the evidence, we find that the appellant has greatly exaggerated his mental health concerns, both during his time in prison to secure preferred accommodation, and subsequently in his quest to remain in this country. We find that he is willing to be untruthful to advance his personal objectives, and to be both controlling and manipulative. Consequently, we conclude that the appellant comes nowhere close to meeting the article 3 threshold in respect of his mental health. Our reasons are detailed below.

98. We consider it significant in respect of our assessment below that a referral to a sleep clinic was made in April 2021, after the appellant was identified as having severe excessive daytime symptoms on the Epworth Sleepiness Scale. He was diagnosed with sleep apnoea. The appellant accepted before us that he did not inform the sleep clinic that he suffered from PTSD, nightmares and flashbacks. We are satisfied that the appellant's most pressing health concern for many years was his inability to enjoy refreshing sleep, with its attendant adverse daily impact upon him. The sleep clinic assessment was of immense importance to him, and we find that he provided correct information to the clinic, as he wanted a diagnosis that would ease his long-standing health problem. We find that the appellant did not 'forget' to inform the clinic that he suffered from PTSD. Rather, he provided his true symptoms, which do not include PTSD, nightmares and flashbacks, to secure a diagnosis addressing his long-standing concerns and permit appropriate treatment.

99. We consider it important that the appellant did not expressly inform Dr Galappathie that he had been diagnosed with sleep apnoea. We are satisfied that he sought to hide the fact during the assessment and was not being truthful when suggesting to us that he may have raised it. We can identify no reason why Dr Galappathie would have failed to reference a relevant issue to his assessment, if he had been informed. We conclude that his act of failing to disclose relevant information was deliberate as he sought to secure from Dr Galappathie a favourable diagnosis of PTSD based, in part, upon his assertion that he was suffering nightmares and flashbacks.

Dr Galappathie's psychiatric reports

100. In addition to over one hundred and fifty pages of GP records and attendant medical documents, the panel has been provided with three psychiatric reports prepared by Dr Galappathie. The original report is

dated 7 December 2020, with addendum reports dated 12 February 2021 and 22 July 2022. The first two document pre-date the publication of the decision in *HA*. The further addendum post-dates.

101. We acknowledge that it is a more straightforward task for a clinician to reach a diagnosis about a physical illness, than it is in the case of mental illness. We also acknowledge that a psychiatrist may well be capable of diagnosing a variety of mental illnesses, including PTSD, following a face-to-face consultation with the individual concerned. However, as observed by the Presidential panel in *HA*, a tribunal will in mental health cases be particularly reliant upon a professional witness fully complying with their obligations as an expert.

102. Ms Gunn acknowledged the panel's concerns addressed at the error of law hearing in December 2021 as to the approach adopted by Dr Galappathie in his December 2020 and January 2021 reports, where he uncritically accepted information provided by the appellant, even though on its face such information was inconsistent with the GP records. Ms Gunn properly conceded that there were clear issues of concern in the approach adopted, which was not consistent with the guidance now provided in *HA*.

103. In preparation for the original report the appellant met Dr Galappathie at a ninety-minute video-call meeting held on 23 November 2020. The appellant's recounting of his symptoms is recorded at para. 72 of the report:

> '72. [The appellant] told me that his symptoms related to PTSD started whilst he was in prison. He said that when he was alone in his cell, he started to reflect on his life and think about all of the events that have occurred including the traumas that he has experienced and that his PTSD symptoms then started to develop. He told me that he started to have recurrent memories about the events that took place. He said that he had difficulty avoiding thinking about the traumas that have occurred. He started to develop flashbacks of the past traumas that were intrusive and distressing and felt like he was living the events again as if he was back there at the time. He also started to experience nightmares. He became tense and fearful. He started to become hypervigilant and became easily startled by loud sounds and noises. He told me that his flashbacks and nightmares initially occurred twice per week in prison. He said that when he was detained under immigration powers, his PTSD symptoms increased and that he started to have flashbacks and nightmares on a daily basis … '

104. Dr Galappathie opined that the appellant suffered severe depressive episode (ICD-10 F32.2), generalised anxiety disorder (ICD-10 F41.1), PTSD (ICD-10 F43.1) and that his risk of self-harm and suicide would be significantly increased by the prospect of being removed to Cameroon.

105. We note that on 23 September 2020, a month before the appellant was granted immigration bail, and two months before his first meeting with Dr

Galappathie, the GP records confirm that a multidisciplinary team (MDT) meeting was held at HMP Maidstone. The appellant's self-identified problems were noted as 'depression, struggling, hopelessness, on-going immigration issues'. His identified diagnosis at the conclusion of his care by the MDT was moderate anxiety (GAD-7(14)), moderate depression (PHQ9(14)) and an indication of problematic personality functioning (SAPA5 (5)). It was agreed at the MDT meeting to refer the appellant for psychology work due to his history of PTSD, and he was discharged from the Team's care. We understand from reading the GP records as a whole that the reference to PTSD concerns the appellant's self-identification as no formal diagnosis of PTSD is identified within the documents.

106. Whilst this information was not before Dr Galappathie when he prepared his reports in December 2020 and January 2021, it was at the time of his further addendum report in July 2022. We address this below.

107. An inspection of the GP records placed before Dr Galappathie at the time of the original report establishes that whilst in the months before the clinical meeting the appellant referenced frustration and low mood to the healthcare team, his last reference to processing traumatic experiences was in October 2019, and no complaints as to flashbacks and nightmares had been made for a considerable time. We note that there was no engagement by Dr Galappathie with the lack of recent entries on the GP records in relation to the appellant suffering hypervigilance, being easily startled, and recounting of flashbacks and nightmares occurring twice a week on occasion.

108. Ms Gunn did not expressly rely in her submissions upon Dr Galappathie's first addendum report, which in part, focused upon the risk of re-offending. In respect of the psychiatric assessment, Dr Galappathie uncritically relied upon the information provided by the appellant approximately three months earlier. We address below the addendum report in respect of the assessment of risk.

109. We turn to the second, or further, addendum report, written by Dr Galappathie after the publication of the panel's error of law decision. It was drafted after a further video-call meeting with the appellant lasting sixty minutes on 24 May 2022.

110. In his further addendum report Dr Galappathie records that he was provided with the appellant's GP records printed on 18 May 2022, which ran from 18 August 1999 to 18 May 2022, almost thirteen years. These records were more extensive than the GP records provided to him in preparation of his original report, which ran from 20 June 2017 to 3 August 2020.

111. Notwithstanding their limitations, GP records concerning an individual detail a specific record of presentation and may paint a broader picture of their mental health than is available to the expert psychiatrist, particularly

where the individual and the GP - and any associated healthcare professionals - have interacted over a significant period of time, during some of which the individual may not have perceived themselves as being at risk of removal. Accordingly, as a general matter, GP records are likely to be regarded by a tribunal as directly relevant to the assessment of the individual's mental health and should be engaged with by the expert in their report. Where an expert's opinion differs from - or might appear, to a layperson, to differ from - the GP records, they will be expected to say so in the report, as part of their obligations as an expert witness.

112. We consider that the detail provided by the GP records permitted Dr Galappathie ample opportunity to assess the consistency of the information provided both to him and to the prison healthcare team by the appellant, and to additionally note earlier medical diagnosis from healthcare psychiatrists, doctors and staff who had engaged with the appellant over time in custody.

113. At the second meeting the appellant informed Dr Galappathie that his mood remained low and continued to worsen. He had difficulty sleeping and woke up during the night continuing to suffer from nightmares. He woke early in the morning, at 4am, and felt tired during the daytime. He stated that he did not enjoy anything in life. He detailed that over the previous three months he heard male and female voices inside his head and through his ears informing him that he has stones in his stomach. The voices became worse at night. He confirmed that he continued to suffer from thoughts about self-harm and suicide, with frequent thoughts to end his life. He expressed thoughts of ending his life by cutting himself. As observed above, the appellant did not inform Dr Galappathie as to his diagnosis of sleep apnoea.

114. Dr Galappathie opined that the appellant was suffering from several symptoms consistent with PTSD, with recurrent and distressing memories of his reported trauma. The appellant's recounting of 'flashbacks by way of images popping into his mind which have been recurrent and distressing' were noted, as were 'nightmares which now occur about twice a week'.

115. The appellant was diagnosed with PTSD (ICD-10 6B40), indicated by delayed response to, and account of, experiencing highly traumatic events whilst serving in Iraq as a nurse. Reliance was placed upon the account of continuing flashbacks by way of images popping into the appellant's mind which were recurrent and distressing.

116. Dr Galappathie further opined that the appellant was suffering from a single episode depressive disorder, severe, without psychotic symptoms (ICD-11 6A70.3), observing that he suffered from a range of depressive symptoms including difficulty in sleeping at night due to suffering from nightmares, and hearing voices.

117. The appellant was identified as suffering from generalised anxiety disorder (ICD-10 6B00), evidenced by frequent panic attacks, the feeling of anxiety and worry, episodes of shaking and suffering from palpitations.

118. In reaching his opinion, Dr Galappathie found that there was nothing to suggest that the appellant was exaggerating or feigning his mental health symptoms, rather they appeared plausible and genuine.

119. We observe that Dr Galappathie's diagnosis is consistent with that detailed in his December 2020 report.

120. We note the failure to expressly engage with the diagnosis identified at the prison healthcare MDT meeting on 23 September 2020, and we consider that the flawed approach adopted in the original report flows into the further addendum report. Whilst time had passed between the MDT meeting and Dr Galappathie's July 2022 assessment, he undertook no examination of the inconsistencies in the account presented to him with that presented over several years to prison healthcare.

121. Turning to the diagnosis of PTSD. Dr Galappathie opined that the appellant suffered from PTSD, as indicated by his account of experiencing several highly traumatic events that 'would be likely to cause pervasive numerous traumatic events whilst serving within Iraq as a nurse'. He accepted the appellant's explanation that having not initially experienced any symptoms of PTSD after the traumatic events, he developed a delayed response to his experiences and his PTSD symptoms started whilst in prison. We note this to be his professional opinion. He also accepted that the appellant suffered from recurrent and distressing flashbacks, as well as twice-weekly nightmares.

122. The diagnosis of PTSD was partly founded upon information provided by the appellant at both meetings. It was also partly drawn from the GP records. As to the latter, Dr Galappathie observed at para. 59 of his further addendum report:

> '59. The diagnosis PTSD would also be supported by his health records which outline that on 20 June 2017 he reported suffering from PTSD and requested referral to the mental health in-reach team for support. On 27 June 2017 he was noted to suffer from nightmares and flashbacks of his friends and soldiers who died in his presence. His PTSD symptoms continued and on 8 July 2019 he was placed on the waiting list for counselling but was advised there was a *'huge waiting list for counselling*'. He later had a course of 7 counselling sessions which ended on 7 November 2020[1]. He has had further psychological therapy in the community.'

[1] This is an error. The appellant attended his seventh, and last, session with a psycho-educational group on 13 November 2019. He engaged in psychological therapy with PTSD Veteran Resolution over sessions from January to March 2022.

123. We find that this assessment of the GP records is founded upon too narrow a reading of the available medical information. When entering the prison estate, and up until 2017, the appellant's primary health complaints concerned his weight, shoulder pain and minor physical ailments, such as soft tissue injury to his leg sustained during a football match in 2016.

124. The appellant exhibited controlling behaviour on several occasions, by seeking to be overbearing and domineering. We consider actions identified in the GP records to be manipulative, for example repeatedly requesting blood tests in October 2011 when previous results were explained to him as being in the normal range and in the same month refusing to have his blood pressure taken because healthcare had not agreed to the regularity of testing he considered appropriate.

125. His self-identification of PTSD, and attendant nightmares and flashbacks was first identified to prison healthcare following his transfer to HMP Brixton in February 2017. Up and until this time, whilst serving in different prison establishments, he had a single cell in various vulnerable prisoners' wings. As is standard following a prison transfer, he underwent reception at HMP Brixton and informed healthcare that he did not feel like self-harming and had not tried to harm himself. This was consistent with observations made previously. He was then placed in a two-person cell. It is established by the GP records that the appellant subsequently adopted various means of securing a single cell, both by seeking to secure the support of healthcare and by approaching senior prison officers elsewhere.

126. An entry on his GP record for 31 March 2017 details, *inter alia*:

> 'He states that he has PTSD and has to have a Single Cell.
>
> He states that he can only be around Veterans and/or Christians – but would be happy to work with me [a nurse] - (until I advised him that I was neither a Veteran or a Christian).
>
> States that he started getting Flashbacks around four years ago – but as the conversation progressed this altered between 5 & 8 years ago.
>
> States that he has to be allocated a Single Cell due to Flashbacks.
>
> He had told his Wing CM [custodial manager] that he is a High Risk CSRA - this is not the case.
>
> This was a brief interview, so content/cause of flashbacks were not explored.
>
> He denies any contact with Mental Health Services – as he feels they will not understand his situation – being neither Veterans or Christians.
>
> Queried his assumption, which was brushed over.'

127. We consider the reference to ‘CSRA’ to be important in our assessment of the appellant’s veracity. The cell sharing risk assessment or ‘CSRA’ (PSI 20/2015) is an essential tool used by HM Prison Service in the identification of prisoners at risk of seriously assaulting or killing a cell mate in a locked cell. There are two levels of risk: ‘high’ and ‘standard’. A high-risk prisoner is one for whom there is a clear indication from evidence of a high level of risk that they may be severely violent to a cell mate, or that a cell mate may be severely violent to them. The appellant clearly exhibited knowledge of the terms and scope of this risk policy.

128. We observe that the appellant’s index offences did not engage severe violence, nor had there been any identification of the appellant using or considering using serious violence recorded in OASys assessment or the GP records until 31 March 2017.

129. We note that the reference to his having been assessed as a high-risk CSRA was untrue.

130. The nurse met the appellant again on 6 April 2017 recording in her note, *inter alia:*

> ‘Met with [the appellant] in order to conduct Clinical Assessment.
>
> …
>
> Spoke briefly of his symptoms of PTSD and diagnosis.
>
> He explained that he has never engaged with Mental Health Services and that PTSD was more visible in him when he has not slept well.
>
> When asked to expand on this he stated that he snores and that this irritates other cell shares – so is not willing to share.
>
> Although this was only briefly spoken about, it would seem that [the appellant] was NOT had a formal diagnosis for PTSD …
>
> Understand that LVS will not be allocating him a Single Cell for mental health grounds.’

131. This is the second occasion the appellant states that he has PTSD but was unable to provide much in the way of detail as to his symptoms.

132. A further meeting was undertaken on 20 April 2017, with the GP records noting, *inter alia*:

> ‘Met with [the appellant] in order to conduct Clinical Assessment.
>
> Very difficult interaction – giving vague answers and being somewhat obstructive – for example, when asking about schooling he spoke at length over how in hindsight he felt it to be insufficient compared to British Schooling System.

> …
>
> [The appellant] stopped interview querying purpose of it – advised that this is to obtain a full interview and identify needs.
>
> He stated that he did not trust me … as I had threatened to Recategorise him – advised that this would not be the case and that I have no such jurisdiction.
>
> He stated that I had said this to him when advising him to find a suitable Cell Share …'

133. We consider his criticism, coupled with untrue accusations, and seeking to control the interview process as again exhibiting controlling and manipulative behaviour.

134. The appellant continued to attend healthcare during May 2017, the root of his complaints being that a shared cell was impacting upon his ability to address his PTSD needs. By 9 May 2017, he raised with healthcare for the first time that he has suicidal thoughts, and expressly stated that he could kill: "I used to have suicidal thoughts when I had just come to prison. I cannot kill myself, but I can kill another person."

135. The nurse further records, *inter alia*:

> 'My cellmate has told me that sometimes I talk in my dreams …
>
> Objectively, he presented in a jovial mood however, he described himself as the devil incarnate at night. He reported to have some nightmares and flashbacks at night of the dead bodies and friends he saw dying while in the army.
>
> Regarding his PTSD, he reported that he gets nightmares whereby he remembers his friends and other soldiers that have died in his presence, he also talked about that being a Nurse he would see dead bodies quite often and some gets some get some flash backs [sic]. He reported that he has served in the Army in Iraq and Afghanistan.
>
> … reported that he knows how to kill and he finds nighttime difficult but he reported having nil intentions.'

136. We observe that threats to kill a cell mate is an outcome relevant to the cell sharing risk assessment. We find that healthcare did not consider the appellant to be credible. The GP records confirm that later in May 2017 the mental health team (MHT) noted the expression of violent thoughts towards others but decided not to accept him onto its caseload.

137. Noting that the express references to being able to kill fall away once he secured a single cell at HMP Brixton, pending referral to relevant services, we find that such assertions were solely a means of using the CSRA to secure his preferred accommodation.

138. Following his securing a single cell, the references to PTSD and suicide ideation begin to disappear from the GP records. We note that he continued to regularly attend healthcare. Soon after securing his new cell, the appellant informed a nurse that he was well, getting up at 5am and active through the day. He identified his stress as arising from his ongoing concerns in relation to deportation.

139. Whilst in prison, the appellant was diagnosed with moderate depression (PHG-9(17)) and severe anxiety (GAD-7(17)). The relevant entry records:

> '[Important]; no evidence of any Severe depressive symptoms observed during assessment. [The appellant] could be anxious of deportation and this is affecting his sleep however he does not appear tired or distress during assessment.'

140. The appellant was offered counselling in June 2017, but declined it as he believed he would have more support when released from prison.

141. We observe that during 2017 and 2018 the appellant expressed no serious mental health concerns, identifying himself as being generally well. There was limited reference to flashbacks, nightmares and PTSD on occasion, but no reference to thoughts of killing someone else.

142. We note that he had greater insight into his immigration position in November 2017, when the respondent informed him that he was liable to deportation. A deportation order was signed on 24 July 2018. We observe below that there was an increase in the appellant's references as to having mental health concerns.

143. Following his transfer to HMP Maidstone, the appellant expressed his irritation with the prison regime. He was suffering from very poor sleep that impacted his day-to-day activities. In January 2019 he declined one-to-one support as he felt that veterans' groups worked better for him. He presented no evidence of depression.

144. In January 2019 he attended healthcare and expressed his anger at the system wanting to deport him to Cameroon. We note his frustration was directed towards the outstanding deportation proceedings, and we observe that for the first time in some years he expressed a non-specific feeling of wanting to harm someone.

145. The appellant claimed asylum and underwent a screening interview on 20 June 2019. Some three weeks later, on 8 July 2019 the appellant requested counselling. He was informed that there was a significant waiting list for counselling services. His asylum interview was held later that month, on 26 July 2019.

146. The appellant attended seven psycho-educational group sessions at HMP Maidstone from September 2019. He stated that he was processing

traumatic experiences. After the seventh session he felt ready to end counselling.

147. His protection and asylum claims were refused by the respondent on 21 January 2020.

148. During the pandemic, and resulting restrictions in the prison estate, the appellant reported struggling emotionally. In the circumstances existing within the prison regime at this time, with prisoners spending many hours locked in their cells, we accept that there was a decline in the appellant's emotional, psychological and physical well-being, no doubt related to being bored, emotionally exhausted and drained by the impact of the pandemic regime imposed. However, during this time he made no references to healthcare as to suffering flashbacks and nightmares. His primary concerns were frustration and feeling low. On occasion he expressed anger at his immigration issues. By 2021 his regular GP appointments were primarily concerned with efforts to lose weight and his on-going sleep problems.

149. We observe that throughout his time in prison the appellant was not diagnosed with PTSD. Psycho-educational sessions were undertaken between September and November 2019, a time when he was awaiting a decision on his asylum application.

150. In February 2022, after the error of law hearing but before promulgation of the panel's decision, the appellant informed his GP that he was receiving counselling from a veteran's counsellor, and that he was suffering flashbacks. We have noted the appellant's regular references to securing support and counselling from veterans' organisations. He detailed in his witness statement of 23 May 2022, 'the veteran PTSD Resolution team is providing me with talking therapy and counselling through their PTSD specialist. I was offered 6-week therapy between January 2022 and March 2022 and ue to the severity of my presentation my therapist agreed to a 7th session of therapy.' We note the letter from Carole Nyman, PTSD Resolution, dated 25 May 2022.

151. Having considered the evidence presented with care, we find that the appellant has for some years exercised manipulative behaviour in respect of his engagement with veterans' organisations. The evidence before us does not identify that these organisations have been provided with his GP records, nor as to whether they have been informed as to his diagnosis by healthcare professionals. The appellant has an established history of embellishing, exaggerating and being untruthful when recounting personal information. We do not accept, in the absence of relevant evidence, that he has provided accurate information to the veterans' organisations as to his mental health. We find that he adopted the manipulative approach of using his engagement with these organisations to impress upon healthcare professionals that he suffered PTSD and related symptoms.

152. We turn at this point to the appellant's reference to suicide ideation. It was at a meeting in December 2020, soon after securing immigration bail and after meeting Dr Galappathie, that he informed his GP as to having suicidal and self-harm thoughts twice a week. We consider the reference at this time to regularity of thoughts to be a conscious decision to ensure consistency between his GP records and the information he had provided to Dr Galappathie on this issue the month before. Up until this point, he is regularly recorded over several years in custody as expressing no thoughts of self-harm or suicide, with the latest entry confirming such view being dated 29 April 2020. There is one entry, on 23 September 2020, referencing the appellant's current mental state as frustration, and identifying that over several days he had suicidal thoughts and anger issues, but no reference was made to suicidal thoughts or self-harm when registering with his GP on 10 November 2020. We again note that when registering with the surgery he detailed his serious illnesses as depression, hypertension and poor sight.

153. We have considered the appellant's assertions in light of the GP records, and do not accept the appellant's evidence that the prison was made aware of such events. Suicide attempts are taken seriously by HM Prison Service. Risk assessment is continuous in prison, both as to risk and potential risk that each prisoner presents to themselves, staff, other detainees and visitors. We judicially note that people in prison who self-harm or express suicidal ideation are placed on a suicide risk management plan called Assessment, Care in Custody and Teamwork (ACCT), which has been implemented in various forms since 2005. At its core, there are multi-disciplinary case review meetings held, the first within 24 hours of a risk of suicide/self-harm being identified, with healthcare participating. We conclude that the silence in the GP notes as to the asserted suicide attempt establishes to the requisite standard that it did not occur.

154. We found the appellant's evidence before us as to his present suicide ideation to be extremely vague. He struggled to cogently explain why he personally considered his current risk of suicide to be very high at the time of signing his 2022 witness statement, when on several occasions he had stated that he would not commit suicide because of his religious beliefs. He informed us that he had not addressed the inconsistency in his witness statement because his solicitor had not asked him to. We consider this answer a weak attempt to deflect. The height of his evidence before us was that he possessed an intention to hurt himself, "because one does not know what will happen tomorrow", whilst confirming that his faith prevented him from killing himself. We conclude that the appellant's recent assertions as to suicide ideation amount to no more than a means of seeking to stay in this country. The same conclusion is reached as to his hearing voices in his head, which he asserted to Dr Galappathie but had never raised previously, or since. We consider that his varied accounts at the hearing of having raised it with other healthcare professionals is not borne out by the GP records.

155. As for refusals to eat, sections 24 to 26 Mental Capacity Act 2005 and the courts recognise that a competent individual over the age of eighteen has the right to choose to refuse food over the age of eighteen years. If a competent adult desires to refuse food until death intervenes, they cannot be force fed or fed artificially without consent. We judicially note that within the prison estate, when a prisoner refuses to take food, a record of all meals refused must be entered in their case notes on the Prison National Offender Management Information System, or P-NOMIS. An ACCT document may be opened at any time during this process, to provide a management plan, but must be opened once the food refusal has gone on for three days. After three days - or one day if fluids are not being taken - wing staff will liaise with healthcare on at least a daily basis as to the status of the food refusal. Healthcare will highlight any ongoing health concerns to the wing manager and Duty Governor. We are satisfied that the second purported hunger strike, lasting five days, would have been recorded on the GP notes if it had occurred. It is not. We conclude to the requisite standard that it did not occur. We are further satisfied that the first purported attempt, said to have lasted three days but again not recorded, did not occur.

156. We conclude that the appellant was untruthful when informing Dr Galappathie that he had thoughts of self-harm and suicide. We further consider Dr Galappathie to have been uncritical in accepting the appellant's assertions when they were not borne out by the GP records.

157. Turning to our conclusions as to whether the appellant suffers from PTSD and related symptoms. We find that the appellant's various references to flashbacks and nightmares are untruthful. We are mindful that there may be good reasons not to raise concerns in respect of PTSD-related symptoms over time. However, for several years, at several prisons, the claimed symptoms were not raised. We are satisfied that if the appellant had suffered flashbacks for several years, he would more likely than not have mentioned them during his regular healthcare attendances before 2017

158. We are satisfied that the appellant raised these concerns in 2017 because he sought a single cell. He was content to act manipulatively to secure his aim. We accept that his sleep apnoea significantly impacted upon the quality of his sleep, resulting in him often waking up unrefreshed in the early hours of the morning. We accept that he uses a light and radio to help him during the night. We accept the requirement to be quiet when awake for several hours, so as not to wake a cell mate, and the inability to put on a light and a radio would adversely impact upon him. We understand his desire to have a single cell, where he could address the effects of his then undiagnosed sleep apnoea on his own terms.

159. Upon transferring to HMP Brixton, we find that the appellant adopted several alternative means to secure a single cell. Firstly, he clearly had an awareness of the cell sharing risk assessment, untruthfully informing

healthcare that he had been assessed as ‘high risk’, defined as ‘one for whom there is a clear indication (from evidence) of a high level of risk that they may be severely violent to a cell mate, or that a cell mate may be severely violent to them’. The relevant prison policy confirms that the assessment seeks to identify, manage and support prisoners and detainees who are at risk of harm to others and from others. It is implemented as part of the Violence Reduction Strategy and is consistent with steps taken by HM Prison Service following the Report of the Zahid Mubarek inquiry in 2006. Having lied in stating that he had previously been assessed as high risk, the appellant repeated over several weeks that he was a veteran who could kill a person. We consider that this was a planned means of securing a single cell. Related observations were not made once he secured the desired single cell. We conclude that the appellant was content to lie, and his manipulation was solely directed to securing the accommodation he wanted.

160. The same manipulative approach was used to try to secure a single cell on mental health grounds. The GP records confirm that the appellant lacked consistency at the outset in identifying when the flashbacks commenced. Having secured a single cell in May 2017, references to flashbacks and nightmares when attending healthcare significantly decreased. We note that subsequent healthcare visits over several years were for mundane matters. We conclude that the self-diagnosis of PTSD in March 2017 was merely a mechanism for securing his preferred cell accommodation.

161. We observe that the appellant exercised manipulation during his index offence. However, whilst this reinforces our conclusion, we are satisfied that his engagement with the prison authorities between March and May 2017 clearly identifies his willingness to manipulate and be untruthful to secure his preferred end.

162. We are satisfied that the appellant pieced together events and personal experiences from working as a nurse in respect of road traffic accidents in the United Kingdom, then interweaved them into a heavily exaggerated history of personal experience whilst serving overseas in Iraq, as a foundation for a self-diagnosis of PTSD. At the relevant time the appellant was aware that mental health concerns could secure single cell accommodation. We find that his preferred engagement with veterans' groups, and avoidance for many years of interventions proposed by healthcare, permitted him to seek to avoid direct medical assessment of his asserted PTSD symptoms.

163. In the circumstances we place no weight upon Dr Galappathie’s diagnosis of PTSD.

Depression and anxiety

164. The most up-to-date medical position for the appellant's mental health is that identified from the conclusions of the MDT in December 2020 – the appellant having moderate depression, moderate anxiety, and problematic personality functioning – which is consistent with present treatment received from his GP, see for example the entry on the GP records dated 8 February 2022. He is prescribed Sertraline, an anti-depressant, once a day.

165. We conclude upon carefully considering his GP records that his depression is connected to frustration as to his present circumstances, including his concern as to being deported to Cameroon. The latter concern will not arise upon his return to Cameroon.

166. Ms Gunn properly accepted that Dr Walker-Said's report considered Sertraline and therapy alone, and did not consider the availability of other, relevant treatment for depression. For that reason, and consequent to our findings above, we do not consider Dr Walker-Said's report as being helpful to us in our assessment.

167. We are satisfied that the appellant's depression comes nowhere close to meeting the article 3 threshold.

Internal Relocation

168. Turning to internal relocation, we observe the Supreme Court judgment in *SC (Jamaica) v. Secretary of State for the Home Department* [2022] UKSC 15, [2022] 1 WLR 3190. In respect of article 3 ECHR, the test is reasonableness rather than a question of whether a person will face a real risk of a breach of article 3 rights. We are required to consider all relevant circumstances looked at cumulatively. That requires a holistic approach involving specific reference to the appellant's personal circumstances, their psychological and physical health, their family and social situation, and their capacity for survival.

169. The primary focus of Ms Gunn's submissions, both orally and in writing, was directed towards the appellant's mental health. For the reasons addressed above, the appellant cannot succeed on mental health grounds in respect of internal relocation.

170. We note the preserved finding of fact at [108] of the First-tier Tribunal decision: the appellant will be able to pass through the airport on his return.

171. Ms Gunn did not expressly rely upon Dr Walker-Said's report dated 23 April 2020. We note various criticisms of the report made by the First-tier Tribunal as well as this panel in our error of law decision. There remains an outstanding issue as to whether Dr Walker-Said is an expert in respect of the safety of Anglophones residing outside NWSW region, but we are not required to engage with that consideration because Dr Walker-Said's opinion as to the appellant being arrested on return was not accepted by

the First-tier Tribunal in the preserved finding addressed above. Given the appellant's particular characteristics of having undertaken no political activity and having spent a significant time outside of the country, there are no substantial grounds that he would be suspected of being sympathetic to separatists because he is an Anglophone originating from the NWSW regions. Further, Dr Walker-Said does not go so far as to opine that all Anglophones returning to Cameroon from abroad are at risk of serious harm.

172. We find the appellant's evidence as to his relationship with QN to be very inconsistent, and we are satisfied that the diminishing of the substance of the relationship was driven by a wish to minimise his connection to potential support in Cameroon. We find that the relationship was an important one, and as he confirmed to his probation officer, for a time in prison he spoke to QN every fortnight, and not irregularly over time as now asserted. We further find that prior to his arrest it had been his intention to return to Cameroon and reside with QN. We are satisfied that because of his son he continues to know where QN lives. However, we accept that it has been some fourteen years since he last visited Cameroon, and after several years in prison, it is much more likely than not that QN has moved on her with life. Whilst she may be able to provide friendship on the appellant's return to Cameroon, we find that she would not be able to provide him with support.

173. We conclude that the appellant has not been truthful as to his family circumstances in Cameroon. We find that he has taken pains to minimise both the numbers of his close family and his present connection with them. No evidence was produced from the three siblings he acknowledges. We note that such evidence was readily obtainable as the appellant informed us that he is in contact with his siblings. Whilst accepting that his father may have had polygamous marriages, we find that the appellant was truthful when informing healthcare staff in May 2017 that his mother had twelve children. We further find that the appellant was not truthful in asserting that he had lost contact with his wider family and was reliant upon information provided by his elder brother in the United States. No cogent reasons were given for his losing contact. We are satisfied that the appellant was not truthful before us in asserting that the uncle whose death upset him was a tribal member, and not a blood relative. The GP entry records significant sorrow, and warmth towards his uncle. The subsequent assertion that this man was no more than a member of his tribe is untrue.

174. The applicant simply sought at the hearing to distance himself from any evidence that could establish a family support network in Cameroon. We conclude that the appellant has remained in contact not just with his close family in this country and the United States, but also with his siblings and wider family in Cameroon.

175. His siblings and wider family can offer financial and emotional support on return to Cameroon. We consider the appellant's evidence at the hearing to be a weak attempt to hide the number of people who could aid him on return. He enjoys a support network on return. This support can be provided to him away from the NWSW region.

176. We do not accept his evidence that he comes from a poor family/tribe. He was able to attend university in the capital, and fund studies in Germany and the United Kingdom. We find that he secured contributions from his family to support him as a student, and the family had sufficient financial resources to offer such support.

177. The appellant can utilise his nursing skills upon return. He is not a poor resident from NWSE region internally displaced from farmland due to the ongoing security conditions in the region. There is no evidence before us establishing that Anglophone nationals are prevented from working in major cities. He can reside in Anglophone-majority areas situated in major cities such as Douala and Yaounde.

178. As addressed above, the appellant's present mental health concerns are primarily related to these proceedings, which will fall away on his return to Cameroon. He can access medication for depression and anxiety.

179. The appellant did not advance before us, either in writing or submissions, the contention raised before the First-tier Tribunal that he could not internally relocate in Cameroon consequent to his service as a nurse in the British military from 2004 to 2009. He was right to do so. There is no evidence before us that the Cameroon authorities target Anglophone nationals in major cities who have a military background, whether with the national or the British military.

180. In the circumstances, we dismiss the appellant's appeal on both challenges advanced.

181. We consider it appropriate to now address Dr Galappathie's first addendum report. We extended an invitation at the conclusion of the error of law hearing in December 2021 for Dr Galappathie to attend the resumed hearing before us and aid our understanding of the approach he adopts to writing his reports. The invitation was not taken up. Instead, a second addendum report was provided. We do not criticise Dr Galappathie for not attending. However, his absence has required us to consider his reports alone, without the benefit of explanation.

182. We observe that Dr Galappathie provided an opinion as to the appellant's risk of reoffending in his first addendum report. This opinion was relied upon by the appellant in his unsuccessful challenge to the section 72 certificate and so was not concerned with an issue before us. However, the panel's clear concerns as to the approach adopted by Dr Galappathie as to his assessment of risk are such that it is considered appropriate that we

articulate our concerns. We observe that for the reasons set out above we have additionally found his reports in this matter to be wanting as to the assessment of the appellant's mental health.

183. By means of a document entitled 'Experience and Qualifications' attached to the addendum, Dr Galappathie confirmed that he received training in the assessment of sexual offenders and regularly conducts risk assessments of this category of offender. He treats several high-risk sex offenders at a registered Locked rehabilitation Hospital.

184. We observe that at the date of the meeting held for the addendum report in November 2020, the appellant had been living in the community for approximately one month, having spent over a decade in custody. Though the report was signed approximately ten weeks later, no further information is identified as having been provided by the appellant.

185. We note that OASys, printed in May 2020, and so six months of age by the time of the meeting in November 2020, identified the appellant as being a high risk to children in the community and a medium risk to a known adult. We understand the latter to be the victim.

186. High risk is defined as there being identifiable indicators of risk of harm and the potential event could happen at any time with serious impact.

187. During his lengthy custodial term, the appellant undertook limited work in three areas:

    i. Think First programme – a supervision programme designed to introduce prisoners to new skills and ways of thinking to help avoid committing further crime
    ii. Enhanced Thinking Skills - an accredited offending behaviour programme that attempts to address thinking and behaviour patterns associated with offending
    iii. Work in relation to alcohol use

188. OASys records that the appellant 'consistently shows no insight into his offending behaviour' or the impact of his offending upon his victim. He 'struggles to see things from other points of view and shows a lack of consequential thinking in his behaviour relating to his offending' and this was 'intrinsically linked to his risk of serious/harm offending behaviour'. There was a 'clear link' between the appellant's attitude towards women/girls/sex and his offending and lifestyle.

189. It was noted that the appellant had targeted a young individual who had put a great deal of trust in him as her father, and the offending showed 'a significant amount of pre-planning to be successful in achieving his aims of sexual gratification'. The appellant failed to engage in offending behaviour work relating to the sexual offending.

190. The appellant's previous employment was identified as not having proven to be a protective factor from committing offences. Additionally, the appellant exhibited a significant element of manipulative/predatory behaviour when offending.

191. In respect of risk, several stable dynamic risks factors were identified. The appellant had pro-criminal attitudes, placing his sexual needs above his child's safety, coupled with a failure to acknowledge responsibility for his offending and minimising responsibility by blaming his wife. His personal relationships were identified as an on-going risk area, in the context of establishing access to children.

192. As for accommodation, it was considered that the appellant should ensure that he does not reside with any young female children, particularly in a familial setting.

193. Alcohol was identified as an acute dynamic factor.

194. As to imminence, OASys details:

> 'It is in my assessment that the risk of serious harm in the community is high given that [the appellant] is yet to complete any offence focused work nor be tested in the community following his custodial sentence. The impact if [the appellant] were to re-offend particularly in a similar manner to the index offence would be serious. [The appellant's] risk would be considered to be particularly imminent where he gets into a new relationship and/or has access to children whom are trusting of him. The risk would be considered very high if it was highlighted that he is living in accommodation with young female children. There are several dynamic risk factors in place and protective factors at this point are insufficient to mitigate risk of serious harm.'

195. The appellant was released to be managed by multi-agency public protection arrangements (MAPPA) at Level 1, it being considered that the risks he posed could be managed by the lead agency in co-operation with other agencies but without the need for formal multi-agency meetings. The relevant risk management plan was therefore considered sufficiently robust to manage his identified risks.

196. In his addendum report, Dr Galappathie noted OASys and observed that the appellant had proven capable of grooming and predatory sexual behaviour against a vulnerable female child with whom he was in a position of trust. He acknowledged that the convictions indicate that the appellant 'repeatedly abused that position of trust for his own sexual gratification and dis-regarded or was unaware of the impact of his offending on his victim'.

197. Dr Galappathie observed that the appellant had completed a long prison sentence. He had completed and benefitted from the Thinking Skills Programme and alcohol awareness work. The appellant was noted to have

avoided further offences in the community – though we observe he had only been released into the community for approximately a month before their meeting – and expressed a wish to avoid alcohol. Vague references to a support network in the community was identified by Dr Galappathie as 'established'. Reliance was placed upon the appellant not having access to children and being willing to 'avoid unsupervised contact with children'.

198. He concluded that the appellant represented a low risk of re-offending in February 2021, having met the appellant in November 2020, and opined that the risk 'will continue to remain low provided he has stable accommodation in the community, ongoing support, does not have access to children and has the opportunity to engage in education and work within the future'. It is striking that no consideration is given to the risk if the appellant has access to children, a relevant factor in the OASys assessment of high risk.

199. We observe that in respect of risk assessment, low risk is defined as no significant, current indicators of harm.

200. Dr Galappathie acknowledged that static risk factors cannot be modified. As to dynamic factors, reliance was placed upon accommodation being provided to the appellant. No consideration was given to whether the appellant was residing in approved premises in accordance with his licence conditions. No engagement is made with an identified dynamic risk factor, namely accommodation permitting access to children. The appellant's willingness to work was also identified as reducing the risk of future offending, despite employment not having been a protective feature at the time of the index offences. Nor were associates and family members previously effective as a protective feature.

201. As for 'thinking and behaviour and attitudes' Dr Galappathie detailed:

> 'In my opinion, it is notable that [the appellant] does not have a past history of sexual offending prior to the index offence. He has no past history of any allegations of a sexual nature against him prior to the index offences. He maintains his innocence for the index offences and that his wife coerced his daughter into making the allegations due to his extra marital relationships. In my opinion, it is not possible to fully explore his thought processes given his maintenance of innocence. He is also not able to complete sex offender courses that require him to admit the offences. However, he has served a lengthy prison sentence and other than his previous interest in extra marital relationships which raises some questions about his thoughts towards women, other than the index offences themselves, there is actually nothing to indicate distorted sexual attitudes especially towards children. He does not report any sexual interest in children and is now required to avoid contact with children. Any abnormalities within thinking and behaviour have therefore been resolved as best possible such that his risk of re-offending will remain low.'

202. We conclude that this is a remarkable, and concerning, conclusion. Previous offending history and the number of offences committed are a static risk factor. They are fundamental in considering an individual's potential to reoffend in the long term. That the appellant had not been subject to previous allegations does not undermine the fact that over several years he subjected his minor daughter to rape and sexual assault. We consider the failure to adequately identify the nature of the offences for which the appellant was convicted as striking. No explanation is given as to why the serving of a long-prison sentence positively impacts upon risk. We cannot see how that is the case in this matter. The appellant is not of such an age that it positively impacts upon sexual arousal and recidivism.

203. We are extremely concerned as to the opinion that save for the index offence, 'there is actually nothing to indicate distorted sexual attitudes especially towards children'. We consider that the index offences alone establish cognitive distortion in sexual attitude towards children, the appellant having displayed specific and general beliefs and attitudes associated with the onset and maintenance of sexual offending towards a female child over several years from the age of six. We conclude that Dr Galappathie failed to have appropriate, if any, regard to what was on any rational view a highly relevant consideration.

204. Whilst acknowledging that risk assessment is highly subjective, we consider the approach adopted by Dr Galappathie to the identification of risk to be extremely concerning. Following careful consideration, we conclude that he could not reasonably conclude that the appellant's identified risk to children in the community was capable of being reduced from high to low in the space of three months following release from detention, where limited offender behaviour programmes had been engaged with and the appellant continued to deny his offending history. No cogent explanation was provided by Dr Galappathie as to why the appellant did not remain a high risk to children in the community, and the risk being particularly imminent where he engages in a new relationship and/or has access to children who are trusting of him. We observe the predatory and manipulative manner he adopted towards his victim. Further, there is no engagement with the high risk arising from the appellant living in accommodation with young female children.

205. It is well-established that it is for a court or tribunal to consider what weight should properly be placed upon evidence, and the approach to expert evidence is no different. It is a judicial decision as to whether opinion evidence can properly be considered 'expert'. The Supreme Court in *Kennedy v. Cordia (Services) LLP (Scotland)* [2016] UKSC 6; [2016] 1 WLR 597, at [43]-[44], approved a section of the South Australian Supreme Court decision in *R v. Bonython* (1984) 38 SASR 45, from which it distilled four key considerations which govern the admissibility of expert evidence. We are satisfied that in respect of risk assessment, the opinion provided by

Dr Galappathie would not have assisted any judge in its task of assessing the section 72 certificate.

206. The duties and responsibilities of an expert witness in civil proceedings are addressed in the oft-cited summary of Mr. Justice Cresswell in *National Justice Cia Naviera SA v. Prudential Assurance Co. Ltd (The Ikarian Reefer)* [1993] 2 Lloyd's Rep 68, 81- 82. Expert evidence presented to the Tribunal should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation. An expert witness should provide independent assistance to the court by way of objective, unbiased opinion in relation to matters within his expertise.

207. Having considered the risk assessment filed in this matter we do not consider Dr Galappathie to have provided objective and expert evidence. Whilst he may in future provide opinion that is sufficiently reasoned and impartial to establish his objectivity and expertise, we agree that our conclusion in this matter can properly be considered by this Tribunal and the First-tier Tribunal in respect of any future risk assessment opinion he prepares.

Notice of Decision

208. The decision of the First-tier Tribunal dated 7 May 2021 involved the making of an error on a point of law and was set aside on 28 March 2022 pursuant to section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007, save for the challenge to the section 72 certificate being dismissed and certain identified findings of fact being preserved.

209. We remake the decision. The appellant's appeal on human rights (article 3 ECHR) grounds is dismissed.

210. The anonymity order is confirmed.

D O'Callaghan
Upper Tribunal Judge
Immigration and Asylum Chamber

14 August 2023