Neutral Citation: [2022] UKUT 00111 (IAC)

HA (expert evidence; mental health) Sri Lanka

Upper Tribunal
(Immigration and Asylum Chamber)

At Field House via Microsoft Teams

THE IMMIGRATION ACTS

Heard on 3 and 4 March 2022
Promulgated on 25 March 2022

Before

THE HON. MR JUSTICE LANE, PRESIDENT
UPPER TRIBUNAL JUDGE RIMINGTON

Between

H A
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the appellant: Ms C. Bayati and Mr N. Paramjorthy (Direct Access, both appearing *pro bono*)

For the respondent: Mr R. Dunlop QC, instructed by the Government Legal Department

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(1) Where an expert report concerns the mental health of an individual, the Tribunal will be particularly reliant upon the author fully complying with their obligations as an expert, as well as upon their adherence to the standards and principles of the expert's professional regulator. When doctors are acting as witnesses in legal proceedings they should adhere to the relevant GMC Guidance.

(2) Although the duties of an expert giving evidence about an individual's mental health will be the same as those of an expert giving evidence about any other matter, the former must at all times be aware of the particular position they hold, in giving evidence about a condition which cannot be seen by the naked eye, X-rayed, scanned or measured in a test tube; and which therefore relies particularly heavily on the individual clinician's opinion.

(3) It is trite that a psychiatrist possesses expertise that a general practitioner may not have. A psychiatrist may well be in a position to diagnose a variety of mental illnesses, including PTSD, following face-to-face consultation with the individual concerned. In the case of human rights and protection appeals, however, it would be naïve to discount the possibility that an individual facing removal from the United Kingdom might wish to fabricate or exaggerate symptoms of mental illness, in order to defeat the respondent's attempts at removal. A meeting between a psychiatrist, who is to be an expert witness, and the individual who is appealing an adverse decision of the respondent in the immigration field will necessarily be directly concerned with the individual's attempt to remain in the United Kingdom on human rights grounds.

(4) Notwithstanding their limitations, the GP records concerning the individual detail a specific record of presentation and may paint a broader picture of his or her mental health than is available to the expert psychiatrist, particularly where the individual and the GP (and any associated health care 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.

(5) Accordingly, as a general matter, GP records are likely to be regarded by the 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 the expert's opinion differs from (or might appear, to a layperson, to differ from) the GP records, the expert will be expected to say so in the report, as part of their obligations as an expert witness. The Tribunal is unlikely to be satisfied by a report which merely attempts to brush aside the GP records.

(6) In all cases in which expert evidence is adduced, the Tribunal should be scrupulous in ensuring that the expert has not merely recited their obligations, at the beginning or end of their report, but has actually

complied with them in substance. Where there has been significant non-compliance, the Tribunal should say so in terms, in its decision. Furthermore, those giving expert evidence should be aware that the Tribunal is likely to pursue the matter with the relevant regulatory body, in the absence of a satisfactory explanation for the failure.

(7) Leaving aside the possibility of the parties jointly instructing an expert witness, the filing of an expert report by the appellant in good time before a hearing means that the Secretary of State will be expected to decide, in each case, whether the contents of the report are agreed. This will require the respondent to examine the report in detail, making any investigation that she may think necessary concerning the author of the report, such as by interrogating the GMC's website for matters pertaining to registration.

DECISION AND REASONS

A. INTRODUCTION

1. This is the decision of the Upper Tribunal, pursuant to section 12(2)(b)(ii) of the Tribunals, Courts and Enforcement Act 2007, following the setting aside by the Upper Tribunal (Upper Tribunal Judge Plimmer; 28 August 2020) of the decision of the First-tier Tribunal (First Tribunal Judge Grimmett; 21 January 2020) to allow the appellant's appeal against the decision of the respondent on 29 April 2019 to refuse the appellant's human rights claim.

2. Upper Tribunal Judge Plimmer made an anonymity direction, on the grounds that the appeal concerns sensitive medical evidence pertaining to the appellant's mental health. Neither party urged us to revisit that direction.

3. The hearing in respect of the re-making decision took place at Field House, via Microsoft Teams, on 3 and 4 March 2022. We heard oral evidence from Dr Persaud and Professor Greenberg, both of whom appeared as expert witnesses. The appellant was present remotely but did not give oral evidence. Neither did the appellant's cousin, who is frequently referred to by him and others as his sister. We shall refer to her as the appellant's cousin/sister.

4. At the hearing, Mr Dunlop QC rightly paid tribute to Ms Bayati and Mr Paramjorthy, both of whom appeared *pro bono*. The Upper Tribunal is extremely grateful to both of them for the significant amount of work involved in preparing for and appearing at the hearing. Both of them have acted in the very best traditions of the Bar.

5. Upper Tribunal Judge Plimmer's "set aside" decision is annexed to the present decision.

B. THE NATURE OF THE APPEAL

6. This appeal concerns the correct approach to be adopted in a human rights appeal in which it is argued that removing an individual from, or requiring them to leave, the United Kingdom would be a breach of section 6 of the Human Rights Act 1998, on the basis that such removal or requirement would be contrary to Article 3 of the ECHR, having regard to the individual's mental ill-health and/or risk of suicide. Determining the correct approach now requires an analysis of the judgment of the Grand Chamber of the European Court of Human Rights in Savran v Denmark (Application no. 57467/15; 7 December 2021).

7. This appeal provides an opportunity for the Upper Tribunal to give guidance in respect of expert reports; in particular, psychiatric reports.

C. THE APPELLANT'S HISTORY AND HIS HUMAN RIGHTS CASE

8. The appellant is a citizen of Sri Lanka, born in 1988. In January 2010, when he was then aged 21, the appellant entered the United Kingdom with entry clearance as a student. His leave in that capacity was, in effect, extended on a number of occasions thereafter, with the result that the appellant's student leave came to an end on 5 February 2016.

9. On 4 February 2016, the appellant applied for a residence card under the EEA Regulations (as then in force), as the family member of an EEA resident. On 28 July 2016, the respondent refused that application, with no right of appeal. The appellant made further applications for a residence card on the same basis on 18 August 2016 and 15 March 2017. Both were refused without a right of appeal.

10. On 12 September 2018, the appellant applied for leave to remain on the basis of his private life; in particular, that he was suffering from depression, for which medication had been prescribed by his GP.

11. As we have already recorded, the respondent refused that application (which she treated as a human rights claim) on 29 April 2019. The respondent found that the appellant did not meet the requirements of paragraph 276ADE of the Immigration Rules because he had not lived in the United Kingdom for the required period; and because there would be no very significant obstacles to the appellant's reintegration into Sri Lanka. The respondent also concluded that there were no exceptional circumstances which would render a refusal of leave a violation of Article 8 of the ECHR. Finally, the respondent found that the appellant's removal would not violate Article 3 of the ECHR, on the basis that his case did not meet the high threshold for succeeding by reference to Article 3 on medical grounds, as identified by the House of Lords in N v SSHD [2005] UKHL 31; [2005] Imm AR 353. In this regard, the respondent noted that the appellant had been prescribed citalopram tablets, which were available in Sri Lanka.

12. In a witness statement signed on 20 August 2021, the appellant says that "I cannot return to Sri Lanka as I have established considerable family

and private life here in the UK where I have resided for over the last decade". He states that he has "built relationships and friendships here in the UK which have allowed me to prosper and thrive and to turn into the person I am today". According to the appellant, removing him from the UK, "would not only deprive me of these people but they too in turn would suffer a loss from my absence and this is not beneficial to the public interest".

13. The appellant states that he suffers "from mental anxiety and depression issues", which are "largely due to my uphill battle with the Home Office in an attempt to regularise my stay and that has taken its toll on me both physically and mentally". The appellant says that he has "for a long time" been "battling with depression, anxiety and suicidal ideations", which are "due to the traumas of my past as outlined in my previous witness statements as I especially long for my father who I lost at a young age". As we shall see, the appellant's father died when the appellant was aged one.

14. The appellant says he has a "vision", in which he keeps "seeing my father coming to my room and inviting me to join him 'to the other side'". The appellant tells us that this "has at times led to suicidal feelings". The pandemic has "pushed me to the limit because I have had to self-isolate from the friends that used to provide me with much comfort and support". Although he had counselling with a Buddhist monk at his local temple, due to lockdowns "this has been on and off".

15. The appellant says he "cannot return to Sri Lanka as I have no savings of my own in order to start my own business and I would not be able to support myself in any manner". He fears that his removal "will result in a drastic and irretrievable breakdown of my health and there will be no coming back for me then". In the United Kingdom the appellant is "treated with dignity and respect and can lead a life free of troubles". In this regard, he cites his cousin/sister's "love and support", although when she travelled to Cyprus on 30 January 2021 "her departure made me feel even more ill". The appellant argues that he is "a law-abiding citizen of this country and I have never broken the law and hope to give back to society with my many talents".

16. In a statement dated 18 September 2019, the appellant said that his father was killed in the line of duty on 8 July 1990, during the Civil War in Sri Lanka. The appellant says he is lucky, in that his father comes to see him regularly "in my bedroom and he stands there and smiles at me, but I can see his arm is badly injured". The appellant stated that his mother and grandmother live in Sri Lanka "but they don't seem to understand that my father is with me here in the UK".

17. At paragraph 9 of the earlier statement, the appellant said that "I had a serious car accident at the end of last year and I cannot help feeling that this has badly affected my brain".

18. In a signed statement dated 20 February 2021, the appellant’s cousin/sister states that the appellant “has never fully recovered from the loss of his father until this very day I console him by providing emotional support and love”. The appellant’s brother, who lives in Australia, “also provides him with comfort and support by consoling him over the telephone whenever [the appellant] mental state takes a turn for the worse”. Over the past few years, the appellant “has had to juggle the uncertainty of his immigration matter with that of his emotional turbulences and this has taken a toll in his well-being”. She does everything she can to keep the appellant “emotionally afloat and help him with financial matters such as helping him pay his rent and providing him with money for food”. The cousin/sister is “certain that if he is returned back to Sri Lanka then he will end his life”.

D. THE EXPERT PSYCHIATRIC EVIDENCE

19. At the hearing, we were asked on behalf of the appellant to consider two psychiatric reports of Dr Persaud. The respondent asked us to consider two psychiatric reports of Professor Greenberg.

20. Dr Persaud’s first report is a “current addendum updated report 02/03/2021”. His second report is a “current addendum updated report 02/12/2021”. The latter was filed and served significantly later than the deadline set by Upper Tribunal Judge Rimington’s directions of September 2021, despite the deadlines for filing and serving the reports being set following consultation on timing with the medical experts. Largely as a result of this failure, the hearing, originally scheduled for 13 and 14 December 2021, had to be adjourned. In an email of 3 December 2021, Dr Persaud apologised for the delay. This was, in part, caused by Dr Persaud’s personal circumstances; but also because “I have also been very busy clinically and found it difficult to fit this report in”. Dr Persaud had “mailed out to the client two psychology tests for the client to fill out that were crucial to the new addendum report to make our case” (sic). Having again apologised for the delay, Dr Persaud said that the tests “were vital for our case” (sic).

21. We shall describe the reports in their chronological order.

Dr Persaud’s first report (2 March 2021)

22. Towards the beginning of this report, Dr Persaud says:

> “In preparing this report I understand my duties to the Court. I have complied with that duty and address this report to the Court”.

23. In a declaration at the end of the report, Dr Persaud states (inter alia):

> “3. I understand that my duty in providing written reports is to help the Court and that this duty overrides any obligation on the part of those who have commissioned the report. I confirm that I have complied with this duty.

4. I have endeavoured to include in this report those matters of which I have knowledge and of which I have been made aware, that might adversely affect the validity of my opinion.

5. I have not without forming an independent view included or excluded anything that has been suggested to me by others, in particular, instructing lawyers."

24. Under the heading "EXPERTISE OF AUTHOR OF REPORT", there is the following:

> "I am a Section 12 Approved Consultant Psychiatrist who has worked in the NHS as a Consultant since 1994 and I have held Consultant appointments at Surrey and Borders NHS Trust, The Bethlem Royal Maudsley Hospitals Trust, Honorary Senior Lecturer at The Institute of Psychiatry, The Institute of Neurology, and John Hopkins University Medical School and Hospital in the USA, where I was a Research Fellow. I qualified from University College London in 1986 in medicine and my academic prizes and distinctions include The Royal College of Psychiatrists Research Medal and Prize as well as their Morris Markowe Prize, The Maudsley Hospital's Denis Hill Prize along with The Osler Medal. I have been elected a Fellow of the Royal College of Psychiatrists plus University College London – the highest honour these institutions can bestow on members. UCL was recently voted in the top five of Universities in the world. I have edited a book with the Royal College of Psychiatrists entitled 'The Mind: A Users Guide'. Amongst other qualifications I hold a First Class Honours Degree in Psychology from UCL (the highest grade it's possible to achieve), a Masters Degree in Statistics, and an MPhil from the Institute of Psychiatry. In the recent past a national newspaper in the UK – the 'Independent on Sunday' voted myself one of the top ten psychiatrists in the UK and 'The Times' Newspaper voted myself one of the top twenty mental health experts in the world. I was recently appointed Visiting Gresham Professor for Public Understanding of Psychiatry and have since become Emeritus Visiting Gresham Professor."

25. Under "HISTORY AND EXAMINATION", Dr Persaud wrote that the appellant "has become anxious and depressed but has been so for most of his life". Reference was made to the appellant's father being in the Sri Lankan army and having died in a bomb explosion when the appellant was just a year old. This meant his mother had to raise him and his brother without any assistance, as a result of which she became depressed. Dr Persaud believed that this "emotionally scarred" the appellant and left him vulnerable to depression and anxiety as part of the formation of his personality. Dr Persaud recorded the appellant having "described having visual hallucinations of his father". The appellant found it very difficult to sleep and concentrate, particularly since the last refusal of his EEA application in 2018.

26. Under the heading "HISTORY AND EXAMINATION FROM MEETING ON 02/08/2019 and 11/09/2019", Dr Persaud wrote that the appellant "has told the GP of his increasing suicidality and as a result of fears of overdose apparently the GP had stopped his anti-depressant medication which unfortunately has had the effect also of worsening his mental state

and is clinically clear to me that his condition has seriously deteriorated since I have seen him on the last two occasions". The report continued by recording that the appellant said he "had been referred for counselling which he has had and he is currently awaiting a referral to secondary care mental health services".

27. Dr Persaud recorded the appellant as having "provided a continuing interest of having visual hallucinations in the form of seeing his father at the foot of his bed". Dr Persaud asked the appellant whether he had informed his GP of this "and he stated that he has, and this is evident from the GP medical records." The appellant told Dr Persaud that "he would much rather end his life here in the UK, than return to Sri Lanka and be with his mother and grandmother. He stated that his mother and grandmother do not understand him and shout at him whenever he mentions seeing his father".

28. At the end of this section of the report, Dr Persaud said "my clinical conclusion remains the same as before and I continue to consider this gentleman to be a very high suicide risk".

29. Under the heading "HISTORY AND EXAMINATION FROM MEETING 01/03/2021," Dr Persaud observed that the appellant "was extremely distressed during the consultation and had blood shot eyes and refused to maintain eye contact and I noted that he had very poor personal hygiene. The appellant was being caused "immense anxiety and stress" as a result of his cousin/sister having suddenly to travel to Cyprus, following a bereavement, together with his impending tribunal hearing.

30. Dr Persaud recorded that the appellant "has also been referred to the mental health team and he has been consulting with them via the phone on a weekly and two weekly basis which continues to confirm that the NHS continue to regard the client as seriously mentally unwell".

31. Later, there is the following:

> "I have had access to more NHS records than I had at the last interview and I note an entry dated 28 Aug 2019 where prominent and distressing symptoms of PTSD are detailed including flashbacks regarding seeing the dismembered body of his dead father following a bomb attack. He is retraumatised whenever exposed to bombing or similar incidents via the news".

32. There then follows a number of references from the GP medical records. Amongst these are:

> "28 July 2020 – the client was finding it difficult to come to terms with a decision from the court and had continuing nightmares, and had been signposted to mental health review and had apparently split from a girlfriend and suffered from insomnia – perceived to be a low suicide risk".

33. At the end of this section, Dr Persaud wrote:

> "All of this supporting evidence including the continuation of treatment on the NHS with no diminution of treatment leads me to conclude he continues to be as unwell mentally as before and so my conclusions are the same as before".

34. It will be recalled that Dr Persaud's conclusion from the 2019 History and Examinations was that he continued "to consider this gentleman to be a very high suicide risk".

35. Under the heading "OPINION", Dr Persaud placed the appellant's risk of suicide as "moderate to very high as he is extremely hopeless about the future".

36. Asked to comment about the judgment of the Supreme Court in AM (Zimbabwe) v SSHD [2020] UKSC 17; [2020] Imm AR 1167, Dr Persaud said "there is clinically no doubt" that the appellant's condition "would significantly deteriorate at the point of removal". Dr Persaud reached this conclusion "from assessing the GP medical records and my own clinical assessment of his condition".

37. A little later in this section, there is this opinion:

> "For clients with this level of psychiatric disorder to recover from suicidality, they have to gain some hope for the future. It is not clear what hope for the future this client could have should she (sic) be returned to Sri Lanka, given his current level of conviction about the catastrophic nature of the consequence. As a result, a forced removal to Sri Lanka could be very ominous indeed".

38. There is then the following paragraph:

> "I have considered the possibility that he might be feigning or exaggerating his mental illness. I have not taken his story at face value but carefully examined his symptomology and his emotional reactions during the interview. I have also considered the evidence before me. It is my clinical opinion that his clinical presentation is consistent with a diagnosis of serious psychiatric disorder, including major depression and he has serious suicidal ideations. In my experience it is extremely difficult to feign a full-blown mental illness (as opposed to individual symptoms)."

Professor Greenberg's first report (29 May 2021)

39. Professor Neil Greenberg is instructed by the respondent. He is a consultant adult, liaison and forensic psychiatrist, based with King's College London. He served in the Royal Navy for more than 23 years, leaving as a Surgeon Captain in the role of the Defence Professor of Mental Health. Professor Greenberg runs "March on Stress", which provides "a range of psychological health consultancy for companies that predictably place their personnel in harm's way". Amongst other matters, he provided psychological input for the Foreign and Commonwealth Office after the events of September 11, 2019; and in Bali after the bombings there on 12 October 2002. He regularly advises

organisations about how best to manage the aftermath of significant incidents, such as the London Ambulance Service after the London bombings in 2005.

40. Professor Greenberg examined the appellant on 29 May 2021. The appellant told Professor Greenberg that his father's grave was nearby to the family house. His mother was very strict and, if he had argued or fought with his brother, his mother would put the appellant outside, telling him "your father will come and take you", pointing at the father's grave. The appellant said he had been quite naughty when he was younger and would fight with his brother and his own friends. On one occasion he threw a rock at a rat and killed it by mistake. The appellant did not regard this poor behaviour as serious. The appellant considered that his brother was favoured over him by his mother and his grandmother.

41. After obtaining three 'A' Levels, the appellant spent a few years at home, "but did not work which he said was quite usual in Sri Lanka". His mother continued to look after him. In the United Kingdom, the appellant did a Degree at the University of Sunderland at their London Campus. His cousin/sister and a few of his uncles paid his fees and gave him money to live on. He enjoyed that period of his life, spending time with his cousin/sister and his friends from university. After he finished his Degree he did a Masters, which he passed with merit. It was then that he applied for an EEA permit, which was refused.

42. The appellant said that he speaks with his mother every few weeks. She is in good health and his grandmother is in reasonable health. The appellant found it hard to talk to his mother. He sees his cousin/sister at weekends and gets on well with her and her husband. The appellant described them as reasonably well off.

43. The appellant had a girlfriend when he was in Sri Lanka but the relationship was not a particularly good one, as he felt she was critical of him. In the United Kingdom, the appellant met a girl who was at university, and who was also from Sri Lanka. This relationship lasted about a year but she became more critical and he told her that the relationship "was not working". When the relationship came to an end, the appellant was "a bit upset".

44. Regarding his medical history, the appellant said that he was on 100mg of sertraline and had been for more than a year. He thought that the sertraline had helped. He saw a social prescriber (named Angela) every two weeks at his GP practice. He got on well with her and said he could talk with her about "everything". He had also seen a mental health nurse, called Jane, but that stopped the previous year. Jane had been trying to help the appellant with his sleep and also to help him "not to see his father when he was asleep". The appellant sometimes heard his father's voice in his head, asking him "to come with me". In Sri Lanka there was a picture in the family home which depicted his father's body

with parts of it missing. The appellant thought looking at this picture triggered hearing his father's voice in his head. He did not remember his father. Sometimes when he was a child, the appellant's mother would say to him that he, not his brother, was his father's favourite son.

45. The appellant said he had thought about harming himself "a couple of times". When he felt like harming himself, he would call his cousin/sister and she would be supportive. He had spoken to Angela and the GP about these thoughts. He had never taken an overdose or otherwise intentionally harmed himself.

46. The appellant told Professor Greenberg that when he had been in Sri Lanka he had dreams about his father but they were not bad dreams. Dreaming about and hearing his father's voice were less common when the appellant was first in the United Kingdom. He thought he had had poor sleep for many years.

47. The appellant told Professor Greenberg that Sri Lanka was not a nice place although it might be for other people. If he was there he would have to stay with his mother and grandmother but he did not want to do this as he did not get on with them. He did not consider that he would be in any danger if returned to Sri Lanka.

48. Professor Greenberg found the appellant did not report any abnormal perceptions, pre-occupations or beliefs that were indicative of the serious mental illness. He did not report any self-loathing or auditory hallucinations. Over the past few months he said he had seen his father in his bedroom wearing a white robe; this happens mostly at night. He said he felt okay about seeing his father as he was used to it.

49. With "gentle persistence", Professor Greenberg found that the appellant was able to focus on the topics they were discussing.

50. Professor Greenberg considered the report of 2 March 2021 by Dr Persaud, as well as one dated 18 September 2019. Professor Greenberg also considered the GP medical records relating to the appellant up to 25 August 2020.

51. Under the heading "Opinion", Professor Greenberg said that there was "no evidence that [the appellant] currently suffers from, or had suffered from, a serious mental health disorder such as a severe depressive disorder or a psychiatric disorder such as bipolar disorder or schizophrenia". Professor Greenberg noted that the appellant's care "is managed entirely within primary care", with his GP prescribing a commonly used antidepressant medication at a very standard dose. He also saw a social prescriber who speaks to him about his troubles and provides basic advice and support.

52. From the medical records, Professor Greenberg noted that the appellant "has never been viewed as at high risk of suicide although he was

referred to a community mental health worker in November 2020 to assess his suicide risk. That assessment found him to be at low risk of suicide and he was not found to require further input from community mental health services". Professor Greenberg also noted that there was no evidence that the appellant had ever self-harmed, although he had thought about it.

53. Professor Greenberg concluded that there was no evidence to suggest the appellant had a severe personality disorder, although "he may meet the criteria for a mild personality disorder". Whilst the appellant certainly had persistent grief difficulties, Professor Greenberg was unable to clearly identify the significant impairment that his grief symptoms have had on his life since he was able to complete his schooling, establish intimate relationships and manage a successful move to the UK and complete a number of degrees here, as well as being employed for around six years in the United Kingdom. Accordingly, the appellant did not meet the diagnostic criteria of prolonged grief disorder.

54. Professor Greenberg did not consider the visualisations by the appellant of his father constituted typical psychotic symptoms. They were likely to be part of the appellant's ongoing grief related to his father's death. The appellant did not describe the visualisations as being any more distressing than hearing his father's voice in his head, which he had done for many years, including when he was in Sri Lanka.

55. Professor Greenberg considered that:

> "In my view, it is more likely than not that his current mental health difficulties began after his immigration status was more closely scrutinised by SSHD and he realised that he faced a significant risk of deportation. In my view, his ongoing mental health difficulties are as a result of the continued deportation proceedings and the understandably significant stress this causes him. As he described his difficulties, and taking account of the medical notes, the most likely diagnoses are either a chronic adjustment disorder … or a depressive disorder …".

56. Of the two, Professor Greenberg considered that "a chronic adjustment disorder is more likely to be the most appropriate diagnosis", with the appellant's symptoms varying considerably "with him having good and bad days".

57. In practice, however, Professor Greenberg considered there to be little difference between the two disorders "and in my view the primary cause of his mental health difficulties has been the immigration proceedings". Nevertheless, the appellant's childhood adversity and associated possible mild personality disorder, together with his ongoing grief, would have made him somewhat more vulnerable to develop mental health difficulties than someone without these characteristics".

58. Professor Greenberg was of the view that "anyone who faces the risk of imminent deportation is likely to experience intense distress which could

predispose them to act in an unpredictable and impulsive manner". Accordingly, from the point when the appellant is told that he will be deported until he is able to resettle in Sri Lanka "it would be prudent to monitor him more closely and appropriately restrict his access to means to harm himself".

59. If returned to Sri Lanka, it would be important for a health care provider to have information about the care that the appellant had received in the United Kingdom. The Sri Lanka equivalent of a GP should be able to prescribe continued antidepressant medication and help the appellant connect with an appropriate source of ongoing support akin to the social prescriber that he had been seeing in his GP practice. The GP and the mental health provider could formulate a plan to ensure the appellant was able to access social support and ongoing non-specialist support, akin to that provided by the social prescriber and the monk with whom the appellant is in contact in the United Kingdom, so as to support the appellant's mental health. If the appellant's mental health should deteriorate significantly, which Professor Greenberg hoped would be temporary during the period of readjustment, then Professor Greenberg noted there is a 24/7 mental health helpline available "and it seems that there is provision of community mental health teams and/or inpatient facilities if they were necessary". Professor Greenberg felt it would be helpful for the appellant to have at least his initial accommodation needs provided for "and if he can be helped to find a job, once his distress levels related to being deported decreased somewhat". Professor Greenberg considered that the appellant's financial needs would be considerably less in Sri Lanka than they are in the United Kingdom. His sister is able to help him financially.

60. Professor Greenberg's report ended with the following Declaration:

> "I Neil Greenberg declare that:
>
> 1 I understand that my duty in providing written reports and giving evidence is to help the Court, and that this duty overrides any obligation to the party by whom I am engaged or the person who has paid or is liable to pay me. I confirm that I have complied and will continue to comply with my duty.
>
> 2 I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
>
> 3 I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
>
> 4 I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.

5 I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to points 3 and 4 above.

6 I have shown the sources of all information I have used.

7 I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.

8 I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.

9 I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, including my instructing lawyers.

10 I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.

11 I understand that;

11.1 my report will form the evidence to be given under oath or affirmation;

11.2 questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;

11.3 the court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues in the proceedings, where possible reaching an agreed opinion on those issues and identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;

11.4 the court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;

11.5 I may be required to attend court to be cross-examined on my report by a cross- examiner assisted by an expert;

11.6 I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

12 I have read Part 35 of the Civil Procedure Rules, the accompanying practice direction and the Guidance for the instruction of experts in civil claims and I have complied with their requirements.

13 I am aware of the practice direction on pre-action conduct. I have acted in accordance with the Code of Practice for Experts."

Dr Persaud's second report (2 December 2021)

61. Under "EXPERTISE OF AUTHOR OF REPORT", there is exactly the same paragraph as features in Dr Persaud's earlier report, set out above.

62. Under "HISTORY AND EXAMINATION", Dr Persaud noted that the appellant's dose of sertraline had been increased to 150mg daily, as a result of "a recent deterioration in [the appellant's] mental state". Dr Persaud indicated his disappointment with the fact that he had not been provided with updated GP medical records.

63. The report continues as follows:

> "The patient confirms that he has begun hoarding his tablets with a view to taking a serious overdose so he is planning to kill himself and has a clear plan to do so which means his risk of suicide must be taken seriously. The patient apparently told Professor Greenberg this as well and I would ask that Professor Greenberg reviews his notes in relation to this assertion.
>
> Another worrying recent development is that there appears to be an active breakdown in the relationship with the only contact left in Sri Lanka for this gentleman, which is his mother. The mother is distressed by the patient's constant recounting of hallucinatory experiences involving the dead father. The mother finds these difficult to contend with and appears to believe that the patient is maintaining that the dead father may still be alive.
>
> From the patient's account this appears to be a possible atypical bereavement reaction to the death of the father or maybe a PTSD symptom but in any event, if his relationship with his mother has broken down, then the prospects for the patient are particularly bleak in terms of managing a return to Sri Lanka, as the mother is the only contact there and a corrosive relationship will only exacerbate his suicidal tendencies.
>
> The mother doesn't appear to understand that there is a medical or psychological or psychiatric explanation for the patient persistently describing these symptoms and instead attributes this constant recounting to him doing so, on purpose perhaps to make the mother feel bad or guilty. It is this misapprehension between them which is leading to a breakdown in a key relationship which will have ominous implications should he be sent back to Sri Lanka."

64. Dr Persaud "administered the PHQ-9 [Patient Health Questionnaire] test and the patient scored 24 which puts him in the severe category for clinical depression". According to a December 2013 study, "responses to item 9 of the PHQ-9 remained a strong predictor of suicide attempt".

65. Dr Persaud also "administered the Generalised Anxiety Disorder Questionnaire (GAD-7)". On this, the appellant scored 16, indicating severe anxiety. Dr Persaud said that the "GAD-7 correlates significantly with measures of anxiety, suicidal tendencies and mental well-being".

66. There is then the following:

> "A letter in the medical records dated 20/11/2020 states that the patient was having suicidal thoughts. GP notes 10/09/2018 refers to thoughts of

self-harm. GP notes 03/07/2019 states when younger used to kill animals now getting vivid imagery of it".

67. GP notes 28/08/2019 states that "he is unable to get images of his father dying out of his head – unable to picture anything but his father dying".

68. The report continues:

> "The care of this patient is not managed entirely within primary care – he was referred to Adult Mental Health Services on 20/11/2020 by his GP and in the letter it states this is because he was having thoughts of suicide so the GP referred the patient to adult mental health services clearly because the GP was worried about suicide risk. Later in the letter it says the patient was happy to be managed by the GP and this to me indicates that the patient was trying to avoid the stigma of secondary care mental health services and preferred to keep well away from formal psychiatry because of fears of the stigma and fears associated with this given his cultural background.
>
> In GP records dated Monday 10th Sept 2018 it states 'thoughts of self-harm but does not have definitive plan'.
>
> 03 July 2019 GP records states: 'when he was younger he used to kill animals now getting vivid imagery of it'
>
> 28th August 2019 GP notes say wellbeing team has seen him and supporting him; also says that he is unable to picture anything but his father dying.
>
> This comment in the medical notes about killing animals when younger is hugely significant and know to predict a variety of deeply problematic mental health and personality issues in later life see reference below.
>
> *Why Family Professionals Can No Longer Ignore Violence Toward Animals Family Relations Volume 49, Issue 1 January 2000 Pages 87-95 Clifton P. Flynn, First Published: 28 June 2008* ***https://doi.org/10.111/j.1741-3729.2000.00087.x***
>
> The comment about mental imagery is also very important; see the reference below:
>
> *Mental Imagery and Emotion in Treatment across Disorders: Using the Example of Depression Cognitive Behaviour Therapy Volume 38, 2009 Abnormalities in mental imagery have been implicated in a range of mental health conditions. Imagery has a particular powerful effect on emotion and as such plays a particularly important role in emotional disorders. In depression, not only is the occurrence of intrusive negative imagery problematic, but also the lack of positive (in particular, future-directed) imagery is important.*
>
> There is also an issue on relying on the fact that the care of the patient is managed largely in primary care in inferring this tells us something reliable about the medical assessment of risk. See this reference below:

Melissa Gabriele Frick, Shirley Ann Butler & David Scott DeBoer (2019): Universal suicide screening in college primary care, Journal of American College Health, DOI: 10.1080/07448481.2019.1645677 To link to this article: https://doi.org/10.1080/07448481.2019.1645677

Fundamental in the implementation of an effective suicide prevention measure is the accurate identification of individuals who are at risk. The need for suicide-specific screening protocols is supported by a 2012 report distributed by the United States (U.S.) Surgeon General and the National Alliance for Suicide Prevention, which details that suicide should be preventable for individuals connected to the care of a medical or behavioural health professional.3 Health People 2020 cites behavioural health goals, which include decreased suicide incidence, enhanced depression screening in primary care settings, and an increased percentage of adults with mental health diagnoses who are linked to professional care.4 A review of medical records from a large U.S. sample of patients who died by suicide found elevated rates of primary healthcare service utilization preceding death. Approximately 50% of patients visited a primary care provider within the month prior to death by suicide, while under 25% had contact with a mental health professional in the month prior to death by suicide. 5 It is important to identify the role primary care providers have in assessing, supporting and providing intervention to those at risk for suicidal ideation. ***While primary care providers are regularly charged with initial assessment and management of patients with suicidal ideation, they often do not feel adequately prepared to address this subject.6 The direct questioning and documentation of suicidal thoughts and behaviours as a component of routine practice is low, even when treating patients with underlying depressive symptomatology.7 The percentage of patients that directly articulate suicidal thoughts or plans without being prompted can also be low, further stressing a need for provider comfort introducing dialogue focused on suicide risk evaluation.8***

In Professor Greenberg's report paragraph 10.1 he states:

He said that when he had been in Sri Lanka, he had dreams about his father; he said that they were not bad dreams. He said that he had also heard his father's voice in his head telling him to join him; however, he did not think he would do so. He thinks his dreams and hearing his father's voice became less common when he was first in the UK. He said that he had experiences "bad days" in terms of his mood being low when he had been in Sri Lanka. He thinks that these occurred when he had been thinking about his father. He said that when he was in Sri Lanka, he was exposed to triggers in the form of his father's grave [which was near to the house in which he lived] and the pictures of his father in the house.

My analysis of his hugely significant paragraph is the following: Triggers in the form of his father's grave is a key point as obviously on returning to Sri Lanka he is going to be exposed to these triggers which he is protected from by being in the UK. The symptom reported here by Prof Greenberg that the patient hears his father's voice telling him to join him is indeed ominous but is being kept at bay by not being 'triggered' by the father's grave – what happens when he returns to Sri Lanka and becomes triggered by physical proximity to his father's grave? This issue of triggers in those who have

experienced the kind of trauma this patient has is well known in the literature to be strongly linked with suicide; see reference below.

Theory-driven models of self-directed violence among individuals with PTSD Current Opinion in Psychology Volume 14, April 2017, Pages 12-17 PTSD is a well-established risk factor for the full range of self-directed violence (SDV). It is also one of the few psychological conditions that distinguish those who think about suicide from those who attempt suicide."

69. Under the heading "OPINION" Dr Persaud concluded as follows:

> "In my opinion the GP records do reveal that the NHS/GP regarded and continue to regard the client as seriously unwell and there are a variety of reasons why this client may not be being seen in the longer term by a psychiatrist and may not be under the care of mental health services as opposed to the GP. The resource strapped NHS means that many very ill patients continue to be managed by the GP rather than specialist services. Also as cited above this patient, like many, appears reluctant to do with reasons of stigma and understanding to be managed by a psychiatrist or mental health services and this is not an uncommon situation when people lack insight or a psychological understanding of what is going on with them, and also when they become hopeless about the possibility of recovery.
>
> My opinion is based on my specialist assessment of the client and also the questionnaire they have filled out and also I have attached significance to the triggers that are liable to occur in Sri Lanka plus I have attached significance to the poor sleep and imagery the patient is plagued with. I continue to view the current state as a significant deterioration.
>
> I believe I have established the client is seriously unwell, and the treatment he receives is in my opinion not sufficient to meet the needs to be reviewed by a specialist given the various complicated parts of his history including the imagery over the death of his father.
>
> I believe that I have provided evidence that his mental health problems are a result of his own history and prolonged grief etc as opposed to his immigration problems. The role of the immigration situation in his mental health problems is to worsen them because of the prospect of a return to a place which is likely to remind someone of an original trauma and trigger them as set out above.
>
> My conclusions are that this patient continues to suffer from serious psychiatric disorder, including Major Depression, visual hallucinations and suicidal ideations.
>
> I would also place his risk of suicide as very high as he is extremely hopeless about the future and I am clinically of the view that his condition has deteriorated since my last addendum report, written following a consultation on 1st March 2021.
>
> I clinically remain of the same view as before, that the patient is not feigning his symptoms, as I have not taken his account at face value and I have carefully re examined his symptoms and his emotional reactions during the

last two consultations. I again would have benefited from updated medical records.

I am extremely concerned for his mental health and I am clinically of the view that his removal will result in a serious deterioration in his mental health at the point of removal and thereafter."

Professor Greenberg's second report (19 January 2022)

70. Professor Greenberg met again with the appellant on 7 January 2022. Professor Greenberg had the benefit of sight of the appellant's GP records, up to 14 December 2021.

71. The appellant told Professor Greenberg that his mood can sometimes be better than it was when he saw him; however, he said his mood is usually poor. He sees his father when he is at home at his house. He said he feels he wants to kill himself in order to "go with him". He speaks with a monk at the temple once a week and goes to it with friends or with his sister. He said he was frustrated by having to speak about the situation with lots of people. He felt he got the same advice from everyone, which did not help him. He did not speak to his mother who was in Sri Lanka and had not done so for more than a year.

72. The appellant told Professor Greenberg that he thought about drinking bleach in order to get to his father. However, he said he loves his sister as well and he has promised that "I will come back again" and he said that he will not "do anything stupid". He said, "that is a promise he will keep". He has some old school friends in Sri Lanka but he had not spoken to them for years. They lived in Colombo. He kept in contact with them for a while following his arrival in the United Kingdom but he had stopped doing so. Professor Greenberg noted that when the appellant was speaking about his friends in Colombo, he appeared less forlorn, and that his facial expression was more positive and he spoke somewhat more spontaneously.

73. The appellant reiterated that he would abide by his promise to his cousin/sister not to harm or kill himself.

74. At section 3 of his report, Professor Greenberg set out the medical records from 15 September 2020 to 14 December 2021. Professor Greenberg also had access to the appellant's supplementary witness statement and that of the cousin/sister, as well as Dr Persaud's psychiatric report of 2 December 2021.

75. Professor Greenberg noted the use made by Dr Persaud of the PHQ-9 test; in particular the study concluding that one item of the test "did indeed predict increased suicide risk". Professor Greenberg considered, however, that Dr Persaud had not recognised that the academic paper in question, cited in support of this proposition, concerned the use of PHQ-9 within electronic medical records from a larger integrated health system. Professor Greenberg regarded this as a very different setting from a

medico legal consultation; and the testing sample included those substantially different in age from the appellant. In any event, the paper concluded that the cumulative risk of suicide death over one year increased from 0.03 amongst those who were not reporting thoughts of death or self-harm to 0.3 amongst those who reported such thoughts nearly every day; that is to say, even in the highest risk group the risk of suicide was 3 in 1000. Overall, the response to PHQ-9 questions about suicide was a "moderate" predictor. Similar concerns existed for the GAD-7

76. Professor Greenberg also took issue with Dr Persaud's view of the significance of the appellant's poor sleep. Whilst agreeing that poor sleep is predictive of poor mental health and increased risk of suicide, poor sleep is not considered to make someone a high risk of suicide.

77. Under the heading "Opinion", Professor Greenberg concluded that currently the appellant "is suffering from a moderately severe depressive disorder". Amongst other things, Professor Greenberg noted that the appellant had been able to attend a celebration at the temple at the end of October 2021, albeit that the appellant did not feel able to stay very long. In November 2021, he had been planning to go to Wales to a retreat with his friends although this was subsequently called off. The appellant's mood could vary over time:

> "Thus despite him presenting at interview with me, as someone who found it difficult to provide comprehensive answers, and who moves slowly and did not spontaneously initiate conversations, on the balance of probabilities, his pervasive mood was moderately – severe rather than severe".

78. Professor Greenberg was now of the view that a diagnosis of a depressive disorder was more appropriate for the appellant, rather than a diagnosis of chronic adjustment disorder, which he had described in his earlier report. Nevertheless, as he had previously indicated, Professor Greenberg considered that from a practical viewpoint there may be little difference between the two disorders. Professor Greenberg's opinion remained:

> "… that the primary cause of [the appellant's] mental health difficulties has been the immigration proceedings although other factors such as his relationships with his family in Sri Lanka, his father's death, and his persisting grief, and his adverse childhood experiences have contributed to his mental health difficulties which as I state above amount to a moderately severe depressive disorder".

79. Turning to risk of suicide, Professor Greenberg noted that, other than in November 2020, the appellant's GP had not referred him on to specialist support, "which I would have expected to have happened if the GP, or social prescriber, considered the suicide risk to be high". In fact, when seen by specialist mental health services in 2020, the appellant was not found to be of substantial risk of suicide and it was felt that his mental health care could be effectively managed within primary care.

80. Furthermore, if the appellant's cousin/sister had been of the view that the appellant was of imminent risk of suicide, Professor Greenberg considered it more likely than not she would have discussed this with a GP or social prescriber; and that she would not have felt it appropriate for the appellant to have periods by himself in his own accommodation.

81. It was also evident that the appellant had been regularly reviewed at the GP practice "and his reported risk of suicide is known to them".

82. All this led Professor Greenberg to conclude that whilst the prediction of suicide risk is in no way an exact science, "I do not currently view [the appellant's] risk of suicide as high or as imminent".

83. Reiterating that predicting suicide is not an exact science, Professor Greenberg categorised the risk of the appellant completing suicide as "moderate [i.e. not low, nor high]". The appellant's current depressive disorder "is the main factor driving the suicide risk".

84. If the appellant were returned to Sri Lanka, he would benefit from active management by a local mental health team who could monitor the risk of suicide. More importantly, the appellant would need help to reconnect with people he had known before for general support, such as the friends he said he had in Colombo and/or monks:

> "In my view, the most useful mental health care approach for [the appellant] would be one that helps him establish a meaningful routine to his day. As I state above, there appears to be no meaningful structure to his day at present and he did not report having any thoughts or plans for his future".

85. On return to Sri Lanka, helping the appellant to be more active would be helpful. This fitted with a model of evidence-based therapy for depression called behavioural activation. The "riskiest" period of time in terms of completed suicide would be during the period after the appellant is told he will be deported and during the immediate period after he returns to Sri Lanka.

86. Professor Greenberg concluded as follows:

> "3.11. In my view, if he is given the care/treatment I outline above when he returns to Sri Lanka then, on balance, he will be able to recover from his depressive disorder and establish some sort of life for himself in Sri Lanka. I note that he reports currently having no real quality of life in the UK and in my view, as he described his days, he simply exists.
>
> 3.12. It is hard to be certain what would happen if [the appellant] were to be returned to Sri Lanka with no support or care at all. There is a risk that he would take his own life, however being back in Sri Lanka may in fact 'force' him to be more active in order to support his basic needs [food, water, shelter etc.] which in turn is likely to improve his mental health. However, I have no doubt that he would find the initial period back in Sri Lanka to be daunting. However, he would also be

able to access general support from non-healthcare personnel such as Monks who may be able to help him with sourcing his basic needs."

E. THE DECISION OF THE GENERAL MEDICAL COUNCIL'S FITNESS TO PRACTISE PANEL (MISCONDUCT) OF 20 JUNE 2008

87. On 20 June 2008, following a four-day hearing, the GMC's Fitness to Practise panel found that Dr Persaud's book "From the Edge of the Couch", published by Bantam Books in 2003, contained passages that he had plagiarised from various sources, including four separate articles. Furthermore, in March 2005, Dr Persaud had articles published in "Progress in Neurology and Psychiatry", the "Times Educational Supplement", and the British Medical Journal, which each contained passages plagiarised from other sources. An article by Dr Persaud published in the "Independent" newspaper on 30 June 2005 contained passages plagiarised from the article of someone else.

88. The panel described these actions as "inappropriate, misleading, dishonest and liable to bring the profession into disrepute". Notwithstanding submissions made by leading counsel on behalf of Dr Persaud, the panel found that Dr Persaud's fitness to practice was impaired. The panel found that "doctors occupy a position of privilege and trust in society and are expected to act with integrity and to uphold proper standards of conduct". The public was entitled to expect doctors to be "honest and trustworthy at all times and [to] adhere to the higher standards of probity". Dr Persaud's plagiarising of other work people's work on multiple occasions represented a "serious breach of the principles that are central to *good medical practice*". The panel concluded that "this amounts to misconduct which is serious". His dishonest conduct had brought the profession into disrepute. The panel considered that "a profession's most valuable asset is its collective reputation and the confidence which that inspires".

89. In determining sanction, the panel heard from a number of Dr Persaud's colleagues. One of these was of the view that Dr Persaud "has done a great service for psychiatry in that he has helped to educate the public about sensible theories concerning psychiatric illness. He has a great ability to convey quite complicated matters in an easy-to-understand fashion to the general public". Various broadcast programmes in which Dr Persaud had participated had "been very beneficial in that his good rapport with the listening public enables him to introduce academics or researchers and enables them to convey their recent advantages and psychiatric disorder widely".

90. Another testimonial spoke of Dr Persaud's "genuine commitment to fostering public understanding in giving an enormous amount of time in sharing his expertise".

91. In mitigation, Dr Persaud's counsel said:

> "Unhappily the work that he has done has clearly been at a considerable cost. By that I mean the constant media demands to which he exposed himself had to be juggled with a busy and distinguished clinical practice as well as academic obligations. It appears, most unhappily, that this had led to a cutting of corners in some of the writing, as you have found".

92. Counsel said that "Dr Persaud clearly deeply regrets [the effect that this has had on the profession] and wishes me to say so and through me and you in public to apologise for the misleading activity that took place".

93. Having taken everything into account, including the testimonials and counsel's submissions, the panel concluded that it was highly unlikely Dr Persaud would ever repeat his actions in the future. Although not condoning Dr Persaud's dishonest actions, the panel concluded that his behaviour, although serious, was not incompatible with continuing to be a registered medical practitioner. Accordingly, the panel suspended Dr Persaud's registration for a period of three months.

94. On 21 June 2008, the "Guardian" newspaper reported:

> "It was the scale of his dishonesty which did for Dr Raj Persaud, the celebrity psychiatrist who was reprimanded and suspended from practice for three months by the General Medical Council last night.
>
> The best-known "mind doctor" in Britain could be either an outstanding practitioner or a matchless media performer for the profession, the GMC decided. But he did not have time to do both. …
>
> Persaud claimed his dual skills made him an ideal "talking head" for psychiatry, compared to what he called "unqualified media pundits who normally dominate the media debate". Personable and fluent, he seemed well-qualified to advise other people on how to run their lives. His undoubted talents made lasting friendships, and several media figures, including Richard Madeley and Judy Finnigan, and the broadcaster Martin Bashir, said last night that they wanted to work with him again."

F. THAMBIAYA V SECRETARY OF STATE FOR THE HOME DEPARTMENT

95. A psychiatric report of Dr Persaud was considered by Upper Tribunal Judge Craig in <u>Thambiaya v SSHD</u> (AA/05907/2010).

96. Although Ms Bayati had initially questioned whether this unreported decision of the Upper Tribunal should be cited by the respondent, she did not pursue the matter at the hearing on 3 and 4 March 2022. We give permission for its citation, as is required by Practice Direction 11.1(b). As we shall see, what Upper Tribunal Judge Craig had to say – and Dr Persaud's awareness of this – may go to the issue of the weight to be given to Dr Persaud's reports in the present appeal.

97. The following passages of Upper Tribunal Judge Craig's decision are relevant:

“33. The psychiatric report from Dr Persaud, which is dated 10 September 2012 following an examination on 28 August 2012, begins by describing, in glowing terms, the "Expertise of Author of Report". Dr Persaud wishes the Tribunal to note, among other matters, that he has "been elected a Fellow of the Royal College of Psychiatrists plus University College London - the highest honour these institutions can bestow on members" and that he has worked in the NHS as a consultant since 1994. Apart from all the prizes he won which are listed, he also records that "amongst other qualifications I hold a first class honours degree in psychology from UCL" which, in case anyone was in any doubt, is said to be "the highest grade its [sic] possible to achieve". He also records that "in the recent past a national newspaper in the UK - "the Independent on Sunday" voted myself one of the top ten psychiatrists in the UK and "The Times" newspaper voted myself one of the top twenty mental health experts in the world".

34. Regrettably, Dr Persaud did not see fit to mention anywhere within his report that in June 2008 the General Medical Council had found him guilty of dishonesty and bringing the profession into disrepute and that he was suspended from practising for three months (which is a matter of public record).

35. It is also apparent from the report which he prepared that, as stated, Dr Persaud's "understanding of the basic facts of the case [was] gleaned from the client".”

G. PRACTICE DIRECTION 10: EXPERT EVIDENCE

98. Practice Direction 10 of the Immigration and Asylum Chambers of the First-tier Tribunal and the Upper Tribunal reads as follows:

“**10. Expert evidence**

10.1. A party who instructs an expert must provide clear and precise instructions to the expert, together with all relevant information concerning the nature of the appellant’s case, including the appellant’s immigration history, the reasons why the appellant’s claim or application has been refused by the respondent and copies of any relevant previous reports prepared in respect of the appellant.

10.2. It is the duty of an expert to help the Tribunal on matters within the expert’s own expertise. This duty is paramount and overrides any obligation to the person from whom the expert has received instructions or by whom the expert is paid.

10.3. Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation.

10.4. An expert should assist the Tribunal by providing objective, unbiased opinion on matters within his or her expertise, and should not assume the role of an advocate.

10.5. An expert should consider all material facts, including those which might detract from his or her opinion.

10.6. An expert should make it clear:

(a) when a question or issue falls outside his or her expertise; and

(b) when the expert is not able to reach a definite opinion, for example because of insufficient information.

10.7. If, after producing a report, an expert changes his or her view on any material matter, that change of view should be communicated to the parties without delay, and when appropriate to the Tribunal.

10.8. An expert's report should be addressed to the Tribunal and not to the party from whom the expert has received instructions.

10.9. An expert's report must:

(a) give details of the expert's qualifications;

(b) give details of any literature or other material which the expert has relied on in making the report;

(c) contain a statement setting out the substance of all facts and instructions given to the expert which are material to the opinions expressed in the report or upon which those opinions are based;

(d) make clear which of the facts stated in the report are within the expert's own knowledge;

(e) say who carried out any examination, measurement or other procedure which the expert has used for the report, give the qualifications of that person, and say whether or not the procedure has been carried out under the expert's supervision;

(f) where there is a range of opinion on the matters dealt with in the report:

(i) summarise the range of opinion, so far as reasonably practicable, and

(ii) give reasons for the expert's own opinion;

(g) contain a summary of the conclusions reached;

(h) if the expert is not able to give an opinion without qualification, state the qualification; and

(j) contain a statement that the expert understands his or her duty to the Tribunal, and has complied and will continue to comply with that duty.

10.10. An expert's report must be verified by a Statement of Truth as well as containing the statements required in paragraph 10.9(h) and (i).

10.11. The form of the Statement of Truth is as follows:

"I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion".

10.12. The instructions referred to in paragraph 10.9(c) are not protected by privilege but cross-examination of the expert on the contents of the instructions will not be allowed unless the Tribunal permits it (or unless the party who gave the instructions consents to it). Before it gives permission, the Tribunal must be satisfied that there are reasonable grounds to consider that the statement in the report or the substance of the instructions is inaccurate or incomplete. If the Tribunal is so satisfied, it will allow the cross-examination where it appears to be in the interests of justice to do so.

10.13. In this Practice Direction:

"appellant" means the party who is or was the appellant before the First-tier Tribunal; and

"respondent" means the party who is or was the respondent before the First-tier Tribunal."

H. GUIDANCE FOR THE INSTRUCTION OF EXPERTS TO GIVE EVIDENCE IN CIVIL CLAIMS 2014

99. Although prepared in connection with civil cases governed by Part 35 of the Civil Procedure Rules 1998, the Guidance for the Instruction of Experts to Give Evidence in Civil Claims 2014 is useful in drawing attention to the Academy of Experts and the Expert Witness Institute, both of which have produced model forms of expert reports.

100. Paragraph 54 of the Guidance reads as follows:

"The details of experts' qualifications in reports should be commensurate with the nature and complexity of the case. It may be sufficient to state any academic and professional qualifications. However, where highly specialised expertise is called for, experts should include the detail of

particular training and/or experience that qualifies them to provide that specialised evidence".

101. Under the heading "sanctions" there is the following:

> "89. Solicitors and experts should be aware that sanctions might apply because of a failure to comply with CPR 35, the PD or court orders.
>
> 90. Whether or not court proceedings have been commenced, a professional instructing an expert, or an expert, may be subject to sanction for misconduct by their professional body/regulators."

I. GENERAL MEDICAL COUNCIL GUIDANCE

102. The GMC's Guidance tells doctors that when they are acting as witnesses in legal proceedings:

> "72. You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.
>
> (a) you must take reasonable steps to check the information.
>
> (b) you must not deliberately leave out relevant information".

J. SD (EXPERT EVIDENCE) LEBANON [2008] UKAIT 00078

103. In SD (Expert evidence) Lebanon [2008] UKAIT 00078, the Asylum and Immigration Tribunal (Senior Immigration Judge Gill and Designated Immigration Judge French) was concerned with an expert report in respect of country conditions in the Lebanon. In paragraph 63 of its decision, the AIT noted that the expert's statement regarding his expertise made mention of positive statements about the expert in judgments of courts and tribunals; and that these had "repeatedly explicitly acknowledged my credentials and accepted my expertise, very rarely have they criticised aspects of my testimony … these criticisms have been either minor or, on examination, have proved to lack substance".

104. At paragraph 67, the AIT observed that the expert had quoted complimentary statements about him from judges of the Court of Appeal in a particular case, but not the majority judgments, where it had been held that an immigration judge had been entitled not to accept the opinion of the expert as to risk on relocation. In another case, the expert had omitted to mention that the tribunal had expressed concern that he went to a source from which a particular answer could be expected, in attempting to establish a matter in issue. Overall, the AIT concluded that the expert's assertion that the criticisms of him had "been either minor or, on examination, have proved to lack substance" was a claim that did not "stand up to examination". The AIT held as follows:

> "73. In general terms, we would say that, where an expert refers the tribunal to cases in which his expertise has been accepted or acknowledged or in which he has received praise, he must, at the same time, refer … the tribunal to any cases which he is aware of and which may detract from what has been said about him in the cases he has referred to. In other words, failure to place before the tribunal such material in an even-handed way may reflect on the weight to be given to the evidence which [is] the subject matter of the expert's report".

K. SHOULD DR PERSAUD HAVE MENTIONED HIS SUSPENSION FROM PRACTICE IN HIS EXPERT REPORTS?

105. We shall deal first with the respondent's case that Dr Persaud ought to have made reference in his reports to his suspension from practice by the GMC and the reasons for it. In cross examination, Dr Persaud denied that the omission was "misleading". Upper Tribunal Judge Craig had not used that word in his decision; he had said the omission to refer to the suspension was "regrettable". At the time of the GMC's decision, Dr Persaud said he had been told by his barrister that the GMC's finding was "bewildering and strange". The misconduct in question was not to do with his work as a clinician. It was, rather, a mistake that occurred in relation to an act of journalism. The matter had begun because Dr Persaud had "exposed" the Church of Scientology in a TV programme and the Church had referred the issue of plagiarism to the GMC.

106. Dr Persaud asked, rhetorically, whether the GMC could make a finding about what was journalistic practice. He referred to the testimonials given on his behalf at the time.

107. Dr Persaud said that he had subsequently had discussions and received advice to the effect that the misconduct was unrelated to his medical practice. The GMC had had a "jurisdictional problem", in that Dr Persaud's mistakes had been in the course of an act of journalism.

108. Dr Persaud told us that he might have taken advice regarding paragraph 34 of Upper Tribunal Judge Craig's decision. It was, however, clear to Dr Persaud that the judge had not read the GMC's findings.

109. Ms Bayati's position on behalf of the appellant was that we should not diminish the weight to be given to Dr Persaud's evidence by reason of his not having included a reference to the GMC suspension in his reports; and that his suspension and the reasons for it were, in any event, immaterial to the subject matter of those reports. She emphasised that Dr Persaud's evidence was that he had sought advice and been told that he was under no obligation to disclose those matters, which were in any event of considerable age. Referring to the AIT's decision in <u>SD</u>, Ms Bayati said that Dr Persaud had not drawn attention in his reports to legal cases in which he had been praised by a tribunal or court. There was, accordingly, no question of Dr Persaud failing to be even-handed.

110. Mr Dunlop and Ms Bayati informed us that their respective researches had not disclosed anything directly on point regarding the duties of an expert witness to reveal past findings of dishonesty. It is, however, clear from the general duties imposed upon expert witnesses that a high duty of candour is expected of them. Furthermore, we consider that the GMC Guidance, referred to above, is important in telling doctors that they must not deliberately leave out relevant information, when acting as witnesses in legal proceedings.

111. The issue, therefore, is whether the issue of Dr Persaud's suspension was relevant in the context of the present appeal proceedings, such that it ought to have featured in his reports. For the reasons we shall give, we firmly conclude that it was.

112. Before us, Dr Persaud's attitude to the GMC's decision to suspend him was problematic. The suggestion he had been advised that the GMC had a "jurisdictional problem" in dealing with him is impossible to reconcile with the stance taken by Dr Persaud's counsel at the hearing, who did not contend the panel did not have power to find misconduct and impose a sanction. In any event, it is quite apparent from the GMC's decision that it took the view Dr Persaud's dishonesty was unarguably a disciplinary matter which fell within the panel's remit. Although the dishonesty did not occur in the course of Dr Persaud's treatment of any patient, it directly concerned his activities as a psychiatrist. Dr Persaud's actions had brought the profession into disrepute. Imposing a sanction on a doctor for doing something that has that effect is unarguably within the scope of the GMC's regulatory regime.

113. That said, the question is whether the matter should have been disclosed in Dr Persaud's reports in the present appeal. The answer depends on whether, in all the circumstances, omitting the information risked misleading a reader of the reports. As Dr Persaud accepted, had his dishonesty arisen in a clinical context, or in giving an opinion in an expert report, then it would unquestionably have been misleading for him to omit it from any subsequent report.

114. The fact that the dishonesty did not occur in such circumstances does not, however, mean Dr Persaud's reports in the present case are not misleading, in omitting reference to the suspension from practice for dishonesty. As the AIT identified in SD, if an expert chooses to go beyond the "bare" recitation of their professional qualifications and experience, the expert assumes a duty to ensure that the additional proffered material represents an "even-handed" or fair picture.

115. In both of his reports in the present appeal, Dr Persaud sought to enhance his professional reputation, in the eyes of the Tribunal, by referring in his section headed "Expertise of Author" to media perceptions of his standing as a psychiatrist:

> "In the recent past a national newspaper in the UK – the "Independent on Sunday" voted myself one of the top 10 psychiatrists in the UK and "The Times" Newspaper voted myself one of the top 20 mental health experts in the world".

116. Mr Dunlop informed us that the "Independent on Sunday" article was published in 2002, before Dr Persaud published his works of plagiarism. There is, in our view, no doubt that the view taken of Dr Persaud in those articles was in part the result of his media activities, "as a populariser of science and psychiatry", to use the words of Fiona Fox, Director of the Science Media Centre of the Royal Institution, who was one of those who gave evidence in Dr Persaud's case before the GMC panel.

117. Furthermore, Dr Persaud chose to illustrate his "expertise" by reference to his appointment as visiting Gresham Professor for the Public Understanding of Psychiatry. Here too, he was going well beyond a recitation of his medical qualifications and experience in a purely clinical context. Notwithstanding the GMC decision, he was still using the public persona he had enjoyed in the early 2000s to burnish his professional profile as a psychiatrist.

118. Bearing in mind the serious and important obligations owed by an expert witness to the court or tribunal in which he or she is giving evidence, there can be no question that Dr Persaud failed to give an even-handed account of his history as a psychiatrist. On the contrary, by failing to disclose the fact that he had been suspended from practice for bringing the profession into dispute as a result of his plagiaristic activities, Dr Persaud's reports are misleading. The impression given by the reports is that he has an unblemished record as an internationally-renowned public face of psychiatry, not just a skilled clinician.

119. The production by an expert witness of a misleading report is, plainly, a significant matter that the court or tribunal must take into account, in deciding the weight to place upon the report and any additional evidence given by the person concerned in the course of the proceedings.

120. In the present case there is also the additional concern that Dr Persaud sought to characterise the praise given to him in the newspapers as "recent", when at least one of the articles (and most probably both) appeared some 20 years ago.

L. ASSESSING THE EXPERT REPORTS

121. Quite apart from the issue of his suspension, we have serious problems with the evidence of Dr Persaud, both in writing and orally. We find that he did not comply with his obligations as an expert witness, instead frequently behaving as befitted an advocate. Our reasons are as follows.

122. In his first report, under the heading "HISTORY AND EXAMINATION FROM MEETING ON 02/08/19 AND 11/09/19", Dr Persaud recorded the appellant as telling him that he had told his GP of

> "increasing suicidality and as a result of fears of overdose apparently the GP had stopped his antidepressant medication which unfortunately has had the effect also of worsening his mental state and it is clinically clear to me that his condition has seriously deteriorated since I have seen him on the last two occasions".

Despite Ms Bayati's attempt to categorise everything under this heading as being nothing more than what the appellant told Dr Persaud, it is clear from the passage just quoted that Dr Persaud was, in fact, reaching a clinical opinion by reference to what the appellant had said, irrespective of whether that was objectively true. There is, in fact, nothing in the medical records to show that the appellant's GP stopped antidepressant medication as a result of any increasing suicidality. On the contrary, the consistent picture is one of low suicide risk, with the appellant's depression being treated by primary care.

123. Mention of primary care brings us to the next problem with Dr Persaud's evidence. In his first report (2 March 2021), under the same heading as above, Dr Persaud recorded that the appellant was "currently awaiting a referral to secondary care mental health services". The records show that a decision was taken by the NHS Adult Community Health Services on 20 November 2020 that the appellant did not merit secondary care. When this was put to Dr Persaud by Mr Dunlop, Dr Persaud said the appellant "may have been confused". That may be so. The point, however, is that Dr Persaud's obligation as an expert witness required him to make it clear to the Tribunal (whether or not he considered it necessary for his own diagnosis) that the appellant had not been considered to merit secondary care. This is part of the expert's obligation to make the Tribunal aware of matters that might adversely affect the validity of the expert's opinion.

124. Dr Persaud's first report refers to the appellant having "provided a continuing interest of having visual hallucinations in the form of seeing his father at the foot of his bed". Dr Persaud said he asked the appellant "whether he has informed his GP of this and he stated that he has, and that is evident from the GP medical records".

125. One looks in vain, however, at the medical records for any reference to hallucinations, as opposed to the frequent references to the appellant having nightmares about the death of his father. Again, whether or not Dr Persaud was entitled to regard the references in the GP records as amounting to the appellant having suffered hallucinations – and whether or not Dr Persaud regarded what the appellant had told him as indicative of hallucinations – he had an obligation to draw the Tribunal's attention to the fact that those who were actually treating the appellant had not recorded him as suffering hallucinations.

126. We also have difficulty with the following passage from the first report of Dr Persaud:

> "I have had access to more NHS records than I had at the last interview and I note an entry dated 28 Aug 2019 where prominent and distressing symptoms of PTSD are detailed including flashbacks regarding seeing the dismembered body of his dead father following a bomb attack. He is re-traumatised whenever exposed to bombing or similar incidents via the news".

127. Although it is correct to say that Dr Persaud does not, in this report, make a specific diagnosis of Post-Traumatic Stress Disorder ("PTSD"), the fact that it is mentioned called for some explanation. The absence of any such explanation leads us to conclude that this is, regrettably, a further instance of Dr Persaud's lack of attention to detail and of his tendency to cast around for anything which might lead a layperson to see the appellant's mental health in the most negative light.

128. It is correct to observe that in the NHS record of the appellant's visit to the GP surgery on 28 July 2020, we see "some post-traumatic stress with regards (sic)". There is, however, nothing in the medical records that suggests any of the professionals who were seeing the appellant considered or even suspected that he might be suffering from actual PTSD.

129. Professor Greenberg took some issue with Dr Persaud's reference to "flashbacks". Given his expertise in treating those affected by trauma, Professor Greenberg is plainly well-qualified to opine on this issue. He described a flashback as an "as if happening now" phenomenon. A flashback is concerned with disassociation linked to trauma. Professor Greenberg did not regard a recurrent memory as amounting to a flashback. He regarded the appellant, at this point, as feeling distressed as a result of seeing a film of explosions in Sri Lanka. Professor Greenberg's stance on the issue of hallucinations was that they were related to the appellant's grief about his father and were not indicative of a major psychiatric illness.

130. In his first report, under the heading "HISTORY AND EXAMINATION FROM MEETING 01/03/2021", Dr Persaud said that "the NHS continued to regard the client as seriously mentally unwell". There was, in fact, no evidence to support that assertion. On the contrary, the most recent medical reports available to Dr Persaud indicated that the appellant did not wish to receive counselling and was having weekly discussions with a monk, which were "really helping him".

131. Dr Persaud's second report is also problematic. He recalls the appellant as having confirmed that "he has begun hoarding his tablets with a view to taking a serious overdose so he is planning to kill himself and has a clear plan to do so which means his risk of suicide must be taken seriously". Dr Persaud said that the appellant "apparently told Professor Greenberg this as well and I would ask that Professor Greenberg reviews his notes in relation to this assertion".

132. There is nothing in Professor Greenberg's reports that begins to show the appellant had said anything of the kind to Professor Greenberg. Ms Bayati did not cross-examine Professor Greenberg on this matter. We are entirely satisfied that the appellant made no such statement to Professor Greenberg.

133. In his second report, Dr Persaud states that he "administered the PHQ-9 test and the patient scored 24 which puts him in the severe category for clinical depression". Dr Persaud then references a study from December 2013 as indicating that responses to item 9 of the PHQ-9 "remained a strong predictor of suicide attempt".

134. Dr Persaud also administered the GAD-7 test, where he tells us scores of 5, 10 and 15 are taken as the cut-off points for mild, moderate and severe anxiety respectively. The appellant is said to have scored 16. Dr Persaud says that the test is also "moderately good at screening three other common anxiety disorders – panic disorder … social anxiety disorder … and post-traumatic stress disorder. The GAD-7 correlate significantly with measures of anxiety, suicidal tendencies and mental well-being".

135. As we have noted, Dr Persaud sent the two questionnaires concerning PHQ-9 and GAD-7 to the appellant by post, having spoken to him about them on the telephone. Dr Persaud was not, accordingly, present when the appellant filled in these questionnaires.

136. A reader of Dr Persaud's second report would infer that the appellant's scores were diagnostically significant. Professor Greenberg, however, was in no doubt in both his written and oral evidence that self-report tests such as the PHQ–9 and GAD-7 are not diagnostic. According to Professor Greenberg, even in purely clinical settings, these tests can only provide an indication of whether someone might be suffering from a mental health problem. In medico-legal settings, he says that it is "wholly possible to provide whatever answers someone wants to in order to appear as ill, or as well, as the person wants to".

137. Insofar as the answer to item 9 in the PHQ–9 is concerned, Professor Greenberg points out that it does not appear Dr Persaud recognised that the paper cited by him concerned the use of the PHQ-9 within electronic medical records from a larger integrated health system. Professor Greenberg says that this is a very different setting from a medico-legal consultation. After adjusting for relevant factors, the cumulative risk of suicide death over one year in respect of item 9 increased from 0.03 amongst those who are not reporting thoughts of death or self-harm to 0.3 amongst those who reported such thoughts nearly every day. Overall, the paper noted that the response to the PHQ questions about suicide remained "a moderate predictor of subsequent suicide death".

138. When he was cross-examined about the diagnostic relevance of the PHQ-9 and GAD-7 tests, Dr Persaud prevaricated. He said they were widely

used as an indicator of mental illness, before saying that there was no test that was definitive in psychiatry. A person could have suicidal thoughts one day but not another day.

139. Overall, we considered that Professor Greenberg to be an impressive witness. Apart from one inconsistency in respect of the issue of hallucinations, Professor Greenberg's written and oral evidence was cogent, detailed, consistent and balanced. On the issue of the significance of the PHQ-9 and GAD-7 tests, we prefer the evidence of Professor Greenberg. The reservations he expresses regarding those tests coincide with the assumption which a layperson could make about them; namely, that it is possible for a person deliberately to score themselves higher or lower than they honestly feel at the time of taking the test.

140. Dr Persaud suggested that the appellant might not have been likely to exaggerate his symptoms, because Dr Persaud says there is a stigma in Sri Lanka relating to mental illness. No such alleged explanation, however, features in his reports. Nor is it compatible with the GP medical records, which disclose no inability on the part of the appellant to speak frankly to at least some of those responsible for his primary care. It is, in our view, a further instance of Dr Persaud acting as an advocate of the appellant.

141. Dr Persaud also suggested that an individual may not wish to exaggerate their symptoms, for fear of being detained under the mental health legislation. He posited this, in the context of being asked whether he accepted that a person in a position of the appellant might have an interest in exaggerating their symptoms of mental ill-health, in order to avoid removal from the United Kingdom.

142. Looking at the evidence as a whole, we do not accept that this suggestion is likely to have played any material part in the appellant's thinking. Neither Dr Persaud nor Professor Greenberg suggested there is a necessary correlation between being at high risk of suicide and being liable to involuntary detention in a mental health facility.

143. Finally, in Dr Persaud's second report, he cites the GP records for 3 July 2019 that "when younger [the appellant] used to kill animals now getting vivid imagery of it".

144. Later on the same page, Dr Persaud repeats that reference before saying:

> "This comment in the medical notes about killing animals when younger is hugely significant and know (sic) to predict a variety of deeply problematic mental health and personality issues in later life see references below.
>
> *Why Family Professionals Can No Longer Ignore Violence Towards Animals Family Relations Volume 49, Issue 1 January 2000 pages 87-95 Clifton P. Flynn, First published: 28 June 2008 …*"

145. It does not appear that Dr Persaud asked the appellant about his interaction with animals. In Professor Greenberg's first report, by contrast, we find this:

> "He told me that he was quite naughty when he was younger and would fight with his brother and his own friends. He said that on one occasion he threw a rock at a rat and killed it by mistake. However, he also told me that his poor behaviour was not serious."

146. In cross-examination, Dr Persaud was asked about the emphasis placed in his second report on the killing of animals by the appellant. He did not resile from describing it as of particular significance. The accidental killing of a rat is, however, far removed from taking some form of pleasure in killing an animal, which we understand to be the inference sought to be drawn by Dr Persaud from the exiguous reference in the GP records, which he does not appear to have seen fit to pursue with the appellant.

147. In his first report, Dr Persaud said:

> "I have considered the possibility that he might be feigning or exaggerating his mental illness. I have not taken his story at face value but carefully examined his symptomology and his emotional reactions during the interview. I have also considered the evidence before me. … In my experience it is extremely difficult to feign a full-blown mental illness (as opposed to individual symptoms)".

148. We regret to say that, in the light of our findings, this statement can be ascribed no weight whatsoever. Not only has Dr Persaud, in various respects, taken the appellant's word at face value without cross-reference to accessible medical records, his overall approach is significantly at variance with what is expected of an expert witness. Dr Persaud has, in reality, assumed the role of advocate for the appellant. In this regard, his reference in his email of 3 December 2021 to the two psychology tests being "crucial… to make our case" and "vital for our case" are highly revealing of his overall attitude.

149. For all these reasons, we decline to place any material weight on the evidence of Dr Persaud, save where it expressly coincides with the evidence of Professor Greenberg.

150. Both Professor Greenberg and Dr Persaud are in agreement that the appellant is suffering from a serious illness. We prefer Professor Greenberg's precise diagnosis; namely, that the appellant "is suffering from a moderately severe depressive disorder". As Professor Greenberg states, this represents a change from his earlier diagnosis of a chronic adjustment disorder. However, importantly, Professor Greenberg reiterates that from a practical viewpoint, there may be little difference between the two disorders.

151. We accept Professor Greenberg's opinion that the primary cause of the appellant's mental health difficulties has been the proceedings in the Tribunals; albeit that other factors, including his father's death and the appellant's persisting grief in respect of that, have contributed to the appellant's mental health difficulties.

152. The key issue is the appellant's risk of suicide. We accept Professor Greenberg's evidence that this risk is not high or imminent but falls to be categorised as moderate. The risk is, as Professor Greenberg says, not dependent on whether the appellant is returned to Sri Lanka. In Professor Greenberg's view, which we accept, the appellant's current depressive disorder is the main factor driving the suicide risk. That risk is likely to continue, as the appellant does not want to return to Sri Lanka.

153. If so returned, however, we accept Professor Greenberg's opinion that the most important things are for the appellant to obtain accommodation and the means of sustenance. In this regard, Professor Greenberg refers to support from friends and/or monks. Meanwhile, the appellant should continue on his antidepressant medication, both in the United Kingdom and in Sri Lanka.

154. If those needs are met, Professor Greenberg considers on balance that the appellant will be able to recover from his depressive disorder and establish "some sort of life for himself in Sri Lanka". This contrasts with the appellant "having no real quality of life in the UK and in my view, as he described his days, he simply exists".

155. Although there is a risk that the appellant would take his own life, we accept Professor Greenberg's opinion that "being back in Sri Lanka may in fact 'force' him to be more active in order to support his basic needs … which in turn is likely to improve his mental health". Nevertheless, Professor Greenberg has no doubt that the initial period back in Sri Lanka would be "daunting" for the appellant.

156. These, then, are our findings of fact regarding the expert medical evidence. Before articulating the relevant law and applying it to the facts, it is, however, necessary to make some general observations concerning psychiatric and other mental health expert reports in proceedings before the Immigration and Asylum Chambers of the First-tier Tribunal and the Upper Tribunal.

M. GENERAL OBSERVATIONS CONCERNING PSYCHIATRIC AND OTHER MENTAL HEALTH EXPERT REPORTS

157. During his evidence, Dr Persaud made the important point that it is often a more straightforward task for a clinician to reach a diagnosis about a physical illness, such as diabetes, than it is in the case of a mental illness. This point has implications for the obligations of those giving expert evidence in respect of an individual's mental state, whether past, present or predicted. In such cases, the Tribunal will be particularly

reliant upon the witness fully complying with their obligations as an expert, as well as upon their adherence to the standards and principles of the expert's professional regulator.

158. Although the duties of an expert giving evidence about an individual's mental health will be the same as those of an expert giving evidence about any other matter, the former must at all times be aware of the particular position they hold, in giving evidence about a condition which cannot be seen by the naked eye, X-rayed, scanned or measured in a test tube; and which therefore relies particularly heavily on the individual clinician's opinion.

159. It is trite that a psychiatrist possesses expertise that a general practitioner may not have. A psychiatrist may well be in a position to diagnose a variety of mental illnesses, including PTSD, following face-to-face consultation with the individual concerned. In the case of human rights and protection appeals, however, it would be naïve to discount the possibility that an individual facing removal from the United Kingdom might wish to fabricate or exaggerate symptoms of mental illness, in order to defeat the respondent's attempts at removal. A meeting between a psychiatrist, who is to be an expert witness, and the individual who is appealing an adverse decision of the respondent in the immigration field will necessarily be directly concerned with the individual's attempt to remain in the United Kingdom on human rights grounds.

160. Notwithstanding their limitations, the GP records concerning the individual detail a specific record of presentation and may paint a broader picture of his or her mental health than is available to the expert psychiatrist, particularly where the individual and the GP (and any associated health care 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.

161. Accordingly, as a general matter, GP records are likely to be regarded by the 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 the expert's opinion differs from (or might appear, to a layperson, to differ from) the GP records, the expert will be expected to say so in the report, as part of their obligations as an expert witness. The Tribunal is unlikely to be satisfied by a report which merely attempts to brush aside the GP records.

162. In all cases in which expert evidence is adduced, the Tribunal should be scrupulous in ensuring that the expert has not merely recited their obligations, at the beginning or end of their report, but has actually complied with them in substance. Where there has been significant non-compliance, the Tribunal should say so in terms, in its decision. Furthermore, those giving expert evidence should be aware that the

Tribunal is likely to pursue the matter with the relevant regulatory body, in the absence of a satisfactory explanation for the failure.

163. Psychiatric reports are often filed and served by an appellant shortly before a hearing in the First-tier Tribunal. The greater emphasis now being placed by that Tribunal on case management should render such instances less common, if not exceptional.

164. The filing of an expert report by the appellant in good time before a hearing means that the Secretary of State will be expected to decide, in each case, whether the contents of the report are agreed. This will require the respondent to examine the report in detail, making any investigation that she may think necessary concerning the author of the report, such as by interrogating the GMC's website for matters pertaining to registration.

165. If the Secretary of State does not agree the contents of the expert report, she should promptly inform the appellant and the Tribunal. In such an event, the appellant will need to make arrangements for the expert to give oral evidence and be cross-examined by the Secretary of State's representative. The availability of technology to facilitate the giving of expert evidence by video should enable even busy professionals, such as consultant psychiatrists, to give evidence from their offices, without significantly delaying the holding of the hearing.

166. What we say in paragraphs 163 to 165 reflects the present position, whereby the Secretary of State rarely files an expert report of her own in the First-tier Tribunal or agrees to the joint instruction of an expert. It is, however, possible that, in future, greater use may be made of joint expert reports.

N. THE LAW ON MENTAL ILL-HEALTH AND SUICIDE RISK

167. We shall first address the general principles concerning mental ill-health and suicide risk in the context of Articles 3 and 8 of the ECtHR. In doing so, we essentially adopt the approach urged upon us by Mr Dunlop, with much of which Ms Bayati agreed.

168. In a landmark judgment, which remains significant notwithstanding developments in the substantive law on Article 3 in so-called "health" cases, the Court of Appeal in J v SSHD [2005] EWCA Civ 629; [2005] Imm AR 409 held that in a "suicide case" the risk of a violation of Articles 3 or 8 fell to be considered in relation to three stages; namely:

    (i) when the appellant is informed that a final decision has been made to remove them from the United Kingdom;
    (ii) when the appellant is physically removed (usually by air); and
    (iii) after the appellant has arrived in the country to which they have been returned.

169. In most cases, stages (i) and (ii) are unlikely to raise any Article 3 issues. This is because the risk of suicide can normally be satisfactorily managed by healthcare professionals and by the respondent, whilst the appellant is in her care.

170. As regards stage (iii), the risk of suicide falls to be treated as a "health" case, where (because the Article 3 ill-treatment cannot be ascribed to any third-party human agency) the threshold for an Article 3 violation is set high.

171. The current articulation of the threshold is to be found in paragraph 183 of the judgment of the Grand Chamber of the European Court of Human Rights (ECtHR) in Paposhvili v Belgium (Application no.41738/10)(13 December 2016); [2017] Imm AR 867:

> "183. The Court considers that the "other very exceptional cases" within the meaning of the judgment in *N. v. the United Kingdom* (§ 43) which may raise an issue under Article 3 should be understood to refer to situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy. The Court points out that these situations correspond to a high threshold for the application of Article 3 of the Convention in cases concerning the removal of aliens suffering from serious illness."

172. In AM (Zimbabwe) v SSHD [2020] 2 WLR 1152, Lord Wilson, giving the judgment of the Supreme Court, had this to say about paragraph 183 of Paposhvili:

> "31. It remains, however, to consider what the Grand Chamber did mean by its
> reference to a "significant" reduction in life expectancy in para 183 of its judgment
> in the Paposhvili case. Like the skin of a chameleon, the adjective takes a different colour so as to suit a different context. Here the general context is inhuman
> treatment; and the particular context is that the alternative to "a significant reduction in life expectancy" is "a serious, rapid and irreversible decline in ... health resulting in intense suffering". From these contexts the adjective takes its colour. The word "significant" often means something less than the word "substantial". In context, however, it must in my view mean substantial. Indeed, were a reduction in life expectancy to be less than substantial, it would not attain the minimum level of severity which article 3 requires. Surely the Court of Appeal was correct to suggest, albeit in words too extreme, that a reduction in life expectancy to death in the near future is more likely to be significant than any other reduction. But even a reduction to death in the near future might be significant for one person but not for another. Take a person aged 74, with an expectancy of life normal

for that age. Were that person's expectancy be reduced to, say, two years, the reduction might well - in this context - not be significant. But compare that person with one aged 24 with an expectancy of life normal for that age. Were his or her expectancy to be reduced to two years, the reduction might well be significant."

173. In MY (suicide risk after Paposhvili) [2021] UKUT 00232 (IAC), the Upper Tribunal (Upper Tribunal Judge McWilliam) held that there was nothing in European or domestic case law to support the contention that Paposhvili does not apply to suicide cases:

> "117. The test to be applied in Article 3 health cases is that found at [183] in Paposhvili as explained by the Supreme Court in AM at [29] -31]; namely, whether the Appellant would face a real risk, on account of the absence of appropriate treatment in the receiving state or the lack of access to such treatment, of being exposed to (i) a serious, rapid and irreversible decline in his state of health resulting in intense suffering, or (ii) a significant, meaning substantial, reduction in life expectancy."

174. Upper Tribunal Judge McWilliam probably regarded it as axiomatic that the "Appellant" in paragraph 117 was "a seriously ill person", as required by the ECtHR in paragraph 183 of Paposhvili. Nevertheless, we are happy to make that point plain. The test articulated in paragraph 117 of MY applies only to a seriously ill person.

175. The Paposhvili threshold test has recently been confirmed by the Grand Chamber in Savran v Denmark (Application no.57467/15)(7 December 2021). The case concerned a national of Turkey who had been resident in Denmark, where he committed offences. The applicant was found to suffer from a personality disorder characterised by immaturity, lack of empathy, emotional instability and impulsivity. A report concluded that the applicant's ongoing threatening and physically aggressive behaviour, with paranoid delusions and formal thought disorder, indicated schizophrenia. The applicant had beaten a carer on the head without any warning and had to be immobilised with belts. He then attacked and beat a carer again, whilst in a severely psychotic state. His condition was subsequently brought under a certain degree of control by medication.

176. In its detailed examination of Paposhvili, the ECtHR in Savran said:

> "131. The Court stressed in the above connection that the benchmark was
> not the level of care existing in the returning State; it was not a question of
> ascertaining whether the care in the receiving State would be equivalent or
> inferior to that provided by the healthcare system in the returning State. Nor
> was it possible to derive from Article 3 a right to receive specific treatment
> in the receiving State which was not available to the rest of the population

(ibid., § 189). In cases concerning the removal of seriously ill persons, the event which triggered the inhuman and degrading treatment, and which engaged the responsibility of the returning State under Article 3, was not the lack of medical infrastructure in the receiving State. Likewise, the issue was not one of any obligation for the returning State to alleviate the disparities between its healthcare system and the level of treatment existing in the receiving State through the provision of free and unlimited healthcare to all aliens without a right to stay within its jurisdiction. The responsibility that was engaged under the Convention in cases of this type was that of the returning State, on account of an act – in this instance, expulsion – which would result in an individual being exposed to a risk of treatment prohibited by Article 3 (ibid., § 192). Lastly, the Court pointed out that whether the receiving State was a Contracting Party to the Convention was not decisive.

132. There has been no further development in the relevant case-law since the Paposhvili judgment (cited above).

3. General considerations on the criteria laid down in the Paposhvili judgment

133. Having regard to the reasoning of the Chamber and the submissions of the parties and third parties before the Grand Chamber, the latter considers it useful with a view to its examination of the present case to confirm that the Paposhvili judgment (cited above) offered a comprehensive standard taking due account of all the considerations that are relevant for the purposes of Article 3 of the Convention. It maintained the Contracting States' general right to control the entry, residence and expulsion of aliens, whilst recognising the absolute nature of Article 3. The Grand Chamber thus reaffirms the standard and principles as established in Paposhvili (cited above).

134. Firstly, the Court reiterates that the evidence adduced must be "capable of demonstrating that there are substantial grounds" for believing that as a "seriously ill person", the applicant "would face a real risk, on

account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy” (ibid., § 183).

135. Secondly, it is only after this threshold test has been met, and thus Article 3 is applicable, that the returning State’s obligations listed in paragraphs 187-91 of the Paposhvili judgment (see paragraph 130 above) become of relevance.

136. Thirdly, the Court emphasises the procedural nature of the Contracting States’ obligations under Article 3 of the Convention in cases involving the expulsion of seriously ill aliens. It reiterates that it does not itself examine the applications for international protection or verify how States control the entry, residence and expulsion of aliens. By virtue of Article 1 of the Convention, the primary responsibility for implementing and enforcing the guaranteed rights and freedoms is laid on the national authorities, who are thus required to examine the applicants’ fears and to assess the risks they would face if removed to the receiving country, from the standpoint of Article 3. The machinery of complaint to the Court is subsidiary to national systems safeguarding human rights (ibid., § 184).

4. Relevance of the Paposhvili threshold test in the context of the removal of mentally ill aliens

137. The Court has consistently applied the same principles in cases concerning the expulsion of seriously ill applicants, irrespective of what particular type of medical issue – somatic or mental – underlay their health condition. In the Paposhvili judgment (cited above), before it proceeded to formulate the new standard, the Court had regard to case-law relating to applicants suffering from both physical and mental illnesses (see paragraph 127 above and the range of authorities cited in Paposhvili, cited above, § 179). In the wording of paragraph 183 of the Paposhvili judgment, the standard refers to “a seriously ill person”, without specifying the type of illness. Thus, it is not limited to any specific category of illness, let

alone
physical ones, but may extend to any category, including mental illnesses,
provided that the situation of the ill person concerned is covered by the

Paposhvili criteria taken as a whole.

138. In particular, in its relevant part, the threshold test established in paragraph 183 of the Paposhvili judgment (cited above), rather than mentioning any particular disease, broadly refers to the “irreversibility” of
the “decline in [a person’s] state of health”, a wider concept that is capable
of encompassing a multitude of factors, including the direct effects of an
illness as well as its more remote consequences. Moreover, it would be wrong to dissociate the various fragments of the test from each other, given
that, as noted in paragraph 134 above, a “decline in health” is linked to

“intense suffering”. It is on the basis of all those elements taken together
and viewed as a whole that the assessment of a particular case should be
made.

139. In the light of the foregoing, the Court considers that the standard in question is sufficiently flexible to be applied in all situations involving

the removal of a seriously ill person which would constitute treatment proscribed by Article 3 of the Convention, irrespective of the nature of the
illness.”

177. Looking at the facts of the applicant’s case in Savran by reference to the tests established in paragraph 183 of Paposhvili, the ECtHR held at paragraph 141 that although schizophrenia “is a serious mental illness, the court does not consider that the condition can in itself be regarded as sufficient to bring the applicant’s complaint within the scope of Article 3 of the Convention”.

178. The ECtHR then looked at the medical evidence concerning the applicant. At paragraph 143, the ECtHR found it unnecessary to decide in the abstract whether a person suffering from a severe form of schizophrenia might be subjected to “intense suffering” within the meaning of the Paposhvili threshold test, as it could not be demonstrated that the applicant’s removal to Turkey exposed him to a serious, rapid and irreversible decline in his state of health resulting in intense suffering, let alone to a significant reduction in life expectancy. Although the applicant’s relapse was likely to result in aggressive behaviour and a significantly higher risk of offences against others, as a result of the worsening of the psychotic symptoms, these results could not be described as “resulting in intense suffering” for the applicant himself.

179. In this regard, the ECtHR held at paragraph 144 that it did not appear the applicant ran a risk of harming himself. On behalf of the applicant, it had been submitted that a drug he was taking for his schizophrenia could cause immune defects or deficiencies. But the ECtHR held that the evidence did not indicate that such defects or deficiencies, if they occurred, would be "irreversible" and would result in "intense suffering" or "significant reduction in life expectancy", such as to satisfy the Paposhvili test.

180. At paragraph 146 and 147, in concluding that the applicant's case did not reach the threshold set by Article 3, the ECtHR reiterated that the threshold had "to remain high for this type of case". Against that background, there was "no call to address the question of the returning state's obligations under this Article in the circumstances of the present case".

181. In our view, Savran is a striking illustration of the fact that the Paposhvili threshold test is a demanding one. Cogent evidence is needed to demonstrate the requirements of the test are met, at each stage of the analysis. In this area, a strict evidence-based approach prevails, with the ECtHR being at pains to emphasise that recourse to speculation must be limited to what is essential for the "forward-looking" assessment inherent in Article 3 cases. This emerges from paragraph 146:

> 146. Even assuming that a certain degree of speculation is inherent in the preventive purpose of Article 3 and that it is not a matter of requiring the persons concerned to provide clear proof of their claim that they would be exposed to proscribed treatment (see *Paposhvili*, cited above, § 186), the Court is not convinced that in the present case, the applicant has shown substantial grounds for believing that, in the absence of appropriate treatment in Turkey or the lack of access to such treatment, he would be exposed to a risk of bearing the consequences set out in paragraph 183 of the judgment in *Paposhvili* and paragraphs 129 and 134 above.

182. So far as concerns Article 8, the Court of Appeal has recently reiterated that Article 8 is not in this contest to be regarded merely as Article 3 with a lower threshold: SL (St Lucia) v SSHD [2018] EWCA Civ 1894. An appellant cannot succeed under Article 8 simply because of their mental ill-health and suicide risk, if those are insufficient and meet the high Article 3 test set by Paposhvili and (now) explained by Savran.

183. Mental ill-health and suicide risk may, however, be combined with other Article 8 factors, so as to create a cumulative case, which enables an appellant to succeed on Article 8(2) proportionality grounds.

O. DECIDING THE APPEAL

184. As we have held, the facts concerning the appellant's mental ill-health and risk of suicide are as set out in the evidence of Professor Greenberg.

185. The appellant did not give evidence. We have, however, had regard to his witness statements and those of his cousin/sister.

186. There is no issue regarding the first and second stages identified by the Court of Appeal in J. The contentious matter is whether there are substantial grounds for believing that the appellant, on and after return to Sri Lanka, would be at real risk of being exposed either:

(i) to a serious, rapid and irreversible decline in his state of health resulting in intense suffering; or
(ii) to a significant (i.e. substantial) reduction in life expectancy.

187. We are in no doubt that the appellant has failed to demonstrate such substantial grounds, such as would have made it necessary for the respondent to dispel any doubts in that regard.

188. The appellant is not, as Dr Persaud asserted, at high risk of suicide (let alone very high risk). He poses a moderate risk. We consider that to accept Ms Bayati's submission that the appellant would be reasonably likely to be without material and medical support in Sri Lanka would be to engage in a degree of speculation, such as the ECtHR rejected in Savran. The appellant has a mother in Sri Lanka. Although he claimed that he has not spoken to her recently, we regard this as a belated, self-serving assertion by someone who knows their chances of remaining in the United Kingdom may be bolstered by a claim to be without relevant family members in the country of proposed return. Although we accept that there may be some failure on the part of the appellant's mother to empathise with his obsession about the death of his father, which he was too young to remember, we agree with Mr Dunlop that the overwhelming likelihood from the totality of the evidence is that she would be able and willing to assist the appellant on his return.

189. Furthermore and in any event, the appellant's cousin/sister has provided financial support for him to be able to live independently with friends in Hertfordshire. Given her commitment to the appellant, we regard it as overwhelmingly likely that she would, if necessary, provide him with such support in Sri Lanka (where the cost of living is significantly less than in South East England).

190. The evidence also shows that the appellant is capable of making and retaining friendships. He lives with friends at present, albeit that he claims not to be able to confide in them. They nevertheless help him in various ways, including taking him to see the doctor. The appellant had friends whilst at college in the United Kingdom. He has, until relatively recently, had a girlfriend.

191. Given all this, whether or not the appellant makes contact with his friends in Colombo (which we in any event consider to be highly likely), he has the social skills to form new friendships.

192. In so saying, we are, of course, aware of the appellant's current poor mental health. We nevertheless accept the expert opinion of Dr Greenberg that, once he has come to terms with his return, the appellant's mental health is likely to improve. Unlike the position in the United Kingdom where, as a result of his unsuccessful attempts to remain on EEA and, more recently, human rights grounds, the appellant is unable to work (as he did whilst he was a student), the appellant can re-enter the world of employment, once he is in Sri Lanka. As Dr Greenberg says, that is likely to restore the appellant's sense of purpose in life, thereby improving his mental health.

193. Until he reaches that point, however, the appellant may well need to continue to receive anti-depressant medication. His current medication is, however, available in Sri Lanka. There is no reason why arrangements cannot be made for him to return with some of his medication and for him to be appraised of where he can access it in Sri Lanka.

194. Although Professor Greenberg is of the view that the appellant would currently benefit from being reviewed by secondary mental health services, or at the very least the mental health nurse who works at his GP surgery, Professor Greenberg has no concerns that the standard of mental health provision in Sri Lanka is such as to raise a real risk that the appellant would be unable to access the kind of care Professor Greenberg has described. In any event, we have seen no evidence to suggest this might be the position.

195. In our view, Professor Greenberg's description of the appellant's immediate post-return position as "daunting" is appropriate. It is very far from being of such a traumatic nature as to give rise to a real risk of suicide or any other Paposhvili harm.

196. For these reasons, the appellant's removal to Sri Lanka would not be reasonably likely to result in a violation of Article 3 of the ECHR.

197. As we have said, a person's mental health and risk of suicide, not being sufficient to reach the Article 3 threshold, cannot without more enable them to succeed by reference to Article 8. Before we turn in detail to that matter, however, it is necessary to consider whether the appellant meets the requirements of paragraph 276ADE of the Immigration Rules. In his case, the relevant sub-paragraph is as follows:

> "(vi) … is aged 18 years or above, has lived continuously in the UK for less than 20 years … but there would be very significant obstacles to the applicant's integration into the country to which he would have to go if required to leave the UK."

198. Having regard to all the evidence, we firmly conclude that there would not be very significant obstacles in the appellant's case. The appellant lived in Sri Lanka for the first 21 years of his life. There is no indication that he has lost the ability to speak Sinhalese. He has close relatives in

that country. He would return there with the academic qualifications that he has obtained in the United Kingdom, which are highly likely to place him in a good position to secure employment. Although currently mentally unwell, there is no evidence that he suffers from any significant physical ailment. For the reasons we have given, the problems resulting from his current mental condition are unlikely to persist, once he is in Sri Lanka. By contrast, however, the appellant's currently semi-isolated state in the United Kingdom present obstacles to his integration here, other than in respect of his friends with whom he lives, his cousin/sister and the health professionals whom he has been seeing.

199. We accordingly turn to the question of whether, as a person who does not meet the Immigration Rules, the appellant nevertheless has an Article 8 private or family life that is of a kind which would render it disproportionate for the respondent to remove him.

200. We are firmly of the view that he does not. The only family life that the appellant has is with his cousin/sister. Both of them, however, are adults. Whilst we accept that the cousin/sister has been a linchpin for the appellant during his disputes with the respondent and his ongoing period of mental ill-health, we find these are insufficient to constitute a family life that would (even combined with his mental condition and risk of suicide) be of such cumulative strength as to make it disproportionate for him to be removed. The cousin/sister has recently spent several months abroad, whilst the appellant was unwell; but he was still able to manage during that time. We also reiterate what we have said about Professor Greenberg's evidence concerning the prospects for an improvement in the appellant's mental health once he is in Sri Lanka.

201. Otherwise, the appellant's Article 8 rights comprise a somewhat exiguous private life, involving those with whom he lives and the healthcare professionals. Again, even putting this together with his relationship with his cousin/sister and his mental health/suicide risk, the scales weigh decisively in favour of the respondent.

P. DECISION

202. The appellant's appeal is dismissed.

203. At paragraph 2 of her error of law decision, Upper Tribunal Judge Plimmer wrote:

> "2. I note that this decision may cause [the appellant] distress and I have therefore asked for it to be promulgated to his legal representative so that they may explain the decision to him with protective factors in place."

204. We make the same request of Ms Bayati and Mr Paramjorthy in respect of our decision. In doing so, we reiterate our thanks for the part that they have both played in these proceedings.

Mr Justice Lane

The Hon. Mr Justice Lane
President of the Upper Tribunal
Immigration and Asylum Chamber

24 March 2022

ANNEX

Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: HU/08629/2019**

THE IMMIGRATION ACTS

Considered on the papers pursuant to rule 34	**Decision Promulgated**
On 28 August 2020	………………………………

Before

UPPER TRIBUNAL JUDGE PLIMMER

Between

HA
ANNONYMITY DIRECTION MADE

Appellant

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

DECISION AND DIRECTIONS (P)

Pursuant to Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/269) I make an anonymity order. Unless the Upper Tribunal or a Court directs otherwise, no report of these proceedings or any form of publication thereof shall directly or indirectly identify the original first Appellant in this determination identified as HA.

Introduction

1. I have made an anonymity direction because this decision refers to sensitive medical evidence pertaining to the respondent's mental health. I shall refer to the respondent as HA. In a report dated 18 September 2019, Dr Persaud, a Consultant Psychiatrist, described HA as "*seriously psychiatrically unwell*" and suffering from "*serious psychiatric disorder including major depression and visual hallucinations*". He opined that HA's risk of suicide was moderate to

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high and he was unfit to give evidence. Having considered that evidence, I am satisfied that HA should be treated as vulnerable in these proceedings.

2. I note that this decision may cause HA distress and I have therefore asked for it to be promulgated to his legal representatives so that they may explain the decision to him with protective factors in place.

Background

3. HA is a citizen of Sri Lanka. He appealed against a decision dated 29 April 2019 refusing him leave to remain, on human rights grounds. In a decision promulgated on 21 January 2020, First-tier Tribunal ('FTT') Judge Grimmett allowed his appeal on Article 3, ECHR grounds. He concluded that HA's high risk of suicide and mental health issues would result in a serious risk of intense suffering and suicide, and in the premises the Article 3 threshold was met.

4. The appellant ('the SSHD') appealed against the FTT's decision, submitting *inter alia* that it was inadequately reasoned. In a decision dated 27 April 2020, FTT Judge Foudy granted permission to appeal, observing that it was arguable that the FTT failed to apply the correct test and gave insufficient reasons.

5. In directions sent to the parties on 23 June 2020, Upper Tribunal ('UT') Judge Lindsley indicated a provisional view that the determination of whether the FTT made an error of law, and if so whether it should be set aside should be determined without a hearing. She made directions permitting the parties to respond to this provisional view and provide further submissions. There has been no response by either party to these directions.

Decision without a hearing

6. This appeal has been affected by the arrangements brought in as a consequence of the Covid-19 emergency, and as a result Judge Lindlsey made the directions she did. Having considered the overriding objective, the issues raised in this appeal and having noted the failure on the part of the parties to respond in accordance with the directions, I have decided that this is an appropriate case to determine on the papers in accordance with rule 34 of the Tribunal Procedure (Upper Tribunal) Rules 2008.

Error of law discussion

7. I am satisfied that the FTT's decision is inadequately reasoned and the judge has entirely failed to direct himself and apply the correct legal test when addressing Article 3 where it is alleged that an applicant is at risk of suicide.

8. The FTT's factual findings are inadequately reasoned. They are contained entirely in two short paragraphs at the end of the decision at [8] and [9]. Dr Persaud's two reports (an initial report dated 11 September 2018 and the updated report dated 18 September 2019) are summarised at [5] to [7]. I now address the findings made at [8] and [9].

9. The FTT appears to accept that HA had the significant mental health concerns described in Dr Persaud's reports "*for some considerable time*". This does not address or take into account the following material evidence:

   (i) The 'subject access request' printout records HA's GP attendance from July 2012. There is no record of HA having presented with serious mental health concerns until 10 September 2018.

   (ii) HA entered the United Kingdom as a student in January 2010, and his leave as a student was successfully extended in November 2010, October 2013 and October 2014. The FTT has not addressed HA's immigration history and how he was able to meet the requirements of the Immigration Rules in pursuing his studies if he was unwell for a lengthy period.

   (iii) The evidence of HA's cousin (who gave evidence before the FTT) and the extent to which HA's concerns regarding his mother and grandmother in Sri Lanka were well founded.

10. The FTT concluded that HA "*remained a very high risk of suicide*" but has failed to resolve the internal inconsistency within Dr Persaud's 18 September 2019 report: at first the judge states that he considers HA "*to be a very high suicide risk*" before then stating "*I would also place his risk of suicide as moderate to high*".

11. The FTT then considered the country background evidence relevant to mental health care in Sri Lanka at [9]. Although the judge referred to the SSHD relying upon "*the March 2012 COI report*", I have not been able to locate a copy of this report in the file and the judge's record of proceedings does not record any reference to this report on behalf of the SSHD. On the other hand, HA's Counsel relied upon GJ and others (post-civil war returnees) Sri Lanka CG [2013] UKUT 00319 (IAC) and the SSHD's country of origin report issued in March 2012 ('the 2012 report') referred to within GJ, within his written and oral submissions to support the proposition that there would be insufficient psychiatric treatment in Sri Lanka. The 2012 report is quoted at length in GJ – this includes evidence that at

the time there were only 25 working psychiatrists in Sri Lanka. It is very difficult to see why the 2012 report was being relied upon when the situation needed to be assessed as at date of hearing (September 2019). I note that the *CPIN Sri Lanka: medical treatment and healthcare*, dated July 2020 describes considerable improvements to mental health facilities, albeit that report clearly post-dates the FTT's decision.

12. In any event, the FTT appears to have wrongly regarded the availability of mental health treatment in Sri Lanka to be irrelevant. Having noted that the expert considers the risk of suicide is high if HA is removed, the FTT "*was, therefore satisfied*" there is a serious risk of intense suffering and suicide and the Article 3 threshold "*is therefore met*". In so finding, the judge has made no self-direction to the relevant law on the Article 3 threshold. The short paragraph summarising the law at [4] does not even mention Article 3. Consequently, the FTT has failed to direct itself in accordance with or apply the following to the available evidence:

    (i) A high threshold applies where there is a risk of suicide upon return and there needs to be an assessment of the severity of the treatment which it is said that the applicant would suffer if removed – see J v SSHD [2005] EWCA Civ 629 [2005] Imm. A.R. 409

    (ii) A further question of considerable relevance is whether the removing and/or the receiving state has effective mechanisms to reduce the risk of suicide – see J and Y and Z (Sri Lanka) v SSHD [2009] EWCA Civ 362. If there are effective mechanisms, that will weigh heavily against an applicant's claim that removal will violate his Article 3 rights.

    (iii) The decision maker must consider whether there is a real risk on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in health resulting in intense suffering – see Paposhvili v Belgium (Application No. 41738/10) [2017] Imm. A.R. 867 and AM (Zimbabwe) v SSHD [2020] UKSC 17; [2020] 2 W.L.R. 1152

Conclusion

13. I am satisfied that the FTT's decision contains errors of law such that it should be set aside for the reasons identified above. No findings of fact are preserved.

Disposal

14. I have had regard to para 7.2 of the relevant *Senior President's Practice Statement* and the nature and extent of the factual findings required in remaking the decision, and I have decided that this is an appropriate case to be remade in the UT. HA is unlikely to give evidence and the factual dispute is likely to be narrow.

Decision

15. The FTT decision contains an error of law such that the decision is set aside, and the decision will be remade in the UT.

Directions

(1) Within 28 days of the date this decision is sent, HA shall file and serve a consolidated indexed and paginated bundle, containing a skeleton argument cross-referencing to the evidence (which should include any updated medical evidence and country background evidence).

(2) The SSHD shall file and serve any evidence in response 21 days before the hearing together with a position statement.

(3) HA shall file and serve any evidence in reply 14 days before the hearing, together with an amended skeleton argument (if appropriate).

(4) The hearing shall be relisted on the first date after 1 November 2020. TE: 2.5 hrs. No interpreter necessary.

Signed: Ms Melanie Plimmer
Judge of the Upper Tribunal

Date: 28 August 2020