Upper Tribunal
(Immigration and Asylum Chamber)

MY (Suicide risk after Paposhvili) [2021] UKUT 00232 (IAC)

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On 6 May 2021	.....

Before

UPPER TRIBUNAL JUDGE McWILLIAM

DEPUTY UPPER TRIBUNAL JUDGE THOMAS

Between

M Y

(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Amended decision pursuant to Rule 42 (The Tribunal Procedure (Upper Tribunal) Rules 2008)

R **epresentation :**

For the Appellant: Mr B Fullbrook, Counsel, instructed by Duncan Lewis & Co Solicitors

For the Respondent: Ms J Isherwood, Home Office Presenting Officer

Where an individual asserts that he would be at real risk of (i) a significant, meaning substantial, reduction in his life expectancy arising from a completed act of suicide and/or (ii) a serious, rapid and irreversible decline in his state of mental health resulting in intense suffering falling short of suicide, following return to the Receiving State and meets the threshold for establishing Article 3 harm identified at [29] – [31] of the Supreme Court's judgment in AM (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17; [2020] Imm AR 1167, when undertaking an assessment the six principles identified at [26] – [31] of J v Secretary of State for the Home Department [2005] EWCA Civ 629; [2005] Imm AR 409 (as reformulated in Y (Sri Lanka) v SSHD [2009] EWCA Civ 362) apply.

Direction Regarding Anonymity – Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008

Unless and until a Tribunal or court directs otherwise, the Appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him or any member of his family. This direction applies both to the Appellant and to the Respondent. Failure to comply with this direction could lead to contempt of court proceedings

DECISION AND REASONS

1.
The Appellant claims to be a citizen of the Occupied Palestinian Authority (OPA). His date of birth is 1 January 1992.

2.
It is the practice of the Tribunal that an anonymity order is made in all appeals raising asylum or international protection claims . [1] We see no reason to interfere with the direction to anonymise the Appellant made by UTJ Pitt on 28 October 2020 .

The b ackground

3.
The Secretary of State seeks to deport the Appellant pursuant to a deportation order dated 27 May 2015 . This follow ed the Appellant ' s conviction on 10 July 2014 at Southwark Crown Court for robbery and assault occasioning actual bodily harm for which he was sentenced to 22 months ' imprisonment. The Appellant made an application to have the deportation order revoked. The Secretary of State refused to revoke the deportation order in a decision dated 16 March 2016. The Appellant appealed against th is decision of the Secretary of State on the grounds that deportation breaches the United Kingdom's obligations under 1951 UN Convention Relating to the Status of Refugees ('Refugee Convention') and his rights under Articles 2, 3 and 8 of 1950 European Convention on Human Rights ('ECHR') . His appeal was dismissed by the First-tier Tribunal (First-tier Tribunal Judge Myers) in a decision that was promulgated on 5 September 2016, following a hearing on 22 August 2016.

4.
The Appellant was refused permission to appeal against the decision of Judge Myers by the First-tier Tribunal and the Upper Tribunal. However , he sought a judicial review of the Upper Tribunal decision refusing him leave by way of a Cart challenge [2] . Permission was refused in the Administrative Court . The Appellant sought permission to appeal this refusal to the Court of Appeal and eventually permission was granted by Hickinbotton LJ on 17 March 2018. In granting permission, Hickinbotton LJ stated as follows:

" In the circumstances, I consider that the appropriate course is to grant permission to proceed with the judicial review, and remit the matter to the Administrative Court . The Secretary of State may wish to consider whether to concede the judicial review, so that the matter is remitted to the Upper Tribunal which might be regarded as the most appropriate forum for the issue of whether the First-tier Tribunal determination is wrong to be considered and determined . "

5.
A consent order was subsequently approved in the Administrative Court whereby the decision of the Upper Tribunal refusing permission to appeal against the First-tier Tribunal was quashed following the grant of permission to apply for judicial review.

The " Error of Law " d ecision

6.
The matter came before Upper Tribunal Judge Craig on 19 September 2019. He found that the judge materially erred and set aside Judge Myers ' decision in a decision dated 22 May 2020. The salient parts of the error of law decision read as follows:-

" 28. Since the hearing, as had been anticipated when AM (Zimbabwe) had been argued in the Court of Appeal, the applicant in that case had appealed further to the Supreme Court and his appeal was heard on 4 December last year.

29. Judgment in that case has only very recently been given (on 29 April 2020) and the Supreme Court ' s decision as set out at paragraph 34 was that ' in the light of the decision in the Paposhvili case, it is from the decision of the House of Lords in the N case that we should depart today ' .

30. In the judgment of this Tribunal now, the jurisdictional background under which this Appellant ' s case falls to be determined is potentially very different from that which applied when Judge Myers reached her decision. Although she was obliged to apply the law as it was believed to be at the time she made her decision (as was the Court of Appeal in AM (Zimbabwe)), the Supreme Court decision in AM (Zimbabwe) , having regard to the ECtHR decision in Paposhvili , has retrospect effect the consequences of which is that Judge Myers ' decision in this case was not reached after careful analysis of the law which, in light of the Supreme Court decision in AM (Zimbabwe) applied. While it may be that even applying the most recent authority the Appellant ' s appeal will still not succeed, he is at least entitled to have the case considered in light of the most recent authority, which may include consideration of whether, and if so to what extent the decision of the Court of Appeal in J is compatible with Paposhvili as considered by the Supreme Court in AM (Zimbabwe) .

31. One of the reasons why Judge Myers may not have analysed the Sprakab Report more fully is because in the light of the jurisprudence it was then believed to be, as she observed (e.g. at paragraph 32), even if the Appellant was to be returned to the Palestinian territories he still would not be able to succeed under Article 3; however, in light of the Supreme Court ' s decision in AM (Zimbabwe) this might not continue to be the case, because there has been no analysis as to the availability of treatment which the Appellant might require, let alone with regard to the suicide risk itself.

32. It follows that, although the judge was bound to follow the jurisprudence such as existed at the time of her decision, technically her failure to have regard to decisions which had not been made by that time was an error of law, and accordingly her decision must be set aside and remade.

33. Accordingly, I make the following directions:-

Directions

1. The appeal will be relisted for a hearing in the Upper Tribunal.

2. Consideration will be given as to whether the appeal should be reheard by a panel, and further directions will be given to the parties in due course " .

7.
On 28 October 2020 Upper Tribunal Judge Pitt issued directions following a case management hearing . She refused the Appellant leave to obtain an expert report on health provision available in OPA and Morocco given the delay and cost that this would require and where material on these matters will be available from other sources.

The Grounds of Appeal

8.
The Appellant appeals against the decision of the Respondent of 16 March 201 6 on the basis that return to OPA would mean he was at a risk of treatment such as would breach the UK's obligations under the Refugee Convention and his rights under Articles 2 and 3 ECHR. Additionally, he submits that removal to either Morocco or OPA would breach his rights under Article 3 ECHR (on health grounds) and Article 8 ECHR.

The i ssues

9.
We have to determine the following questions of fact; -

a)
Whether the Appellant is excluded from protection of the Refugee Convention : Article 33(2) of the Refugee Convention and Article 14(5) of the Council Directive (2004/83/EC) (Qualification Directive) with reference to s.72 Nationality, Immigration and Asylum Act 2002.

b)
Whether the Appellant is a citizen of Morocco or OP A .

c)
Whether the Appellant is at risk of persec ution under the Refugee Convention on return to the country of his nationality or (if excluded from protection of the Refugee Convention) he is at risk of t reatment including torture or "inhuman or degrading treatment or punishment" breaching his rights under Art icle s 2 and 3 ECHR .

d)
W hether returning the Appellant to OP A or Morocco will breach his rights under Art icle 3 ECHR on the grounds that because of his mental illness he would face a real risk of being exposed to a serious, rapid and irreversible decline in his state of health resulting in intense suffering and a significant, meaning substantial, reduction in life expectanc y ('Article 3 health grounds') . If not, whether the decision breaches the Appellant's rights under Article 8 ECHR .

10.
The final question involves a question of law, arising from submissions advanced by Ms Isherwood concerning the applicatio n of Y (Sri Lanka) v SSHD [2009] EWCA Civ 362 and J v SSHD [200 5] EW CA Civ 629 ; [2005] Imm AR 409 following Paposhvili v Belgium 2016 ECHR 41738/10; [2017] Imm AR 867 and AM (Zimbabwe) v SSHD [2020] UKSC 17 ; [2020] Imm AR 1167 .

The law

11.
For the reasons we go on to explain, this appeal is allowed on the Article 3 health ground s. We will start with setting out the law in respect of Article 3 health cases because , in our view, this is the determinative issue in this appeal.

12.
The Grand Chamber in Paposhvili recast the test to be applied in Article 3 health cases. It expressed the view in paragraph 182 that the approach to health cases should be clarified. The court then stated as follows :-

“ 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. ”

13.
The Court of Appeal analysed the effect of Paposhvili (AM (Zimbabwe) v SSHD [2018] EWCA Civ 64 ; [2018] Imm AR 737) . It was the court’s view that the decision relaxed the N test (N v United Kingdom 2008 ECHR 26565/05; [2008] Imm AR 657) for violation of Article 3 in the case of a foreign national with a medical condition “only to a very modest extent”. O n appeal , the Supreme Court in AM i n explaining why it disagreed with the Court of Appeal’s approach stated as follows :

29. The criticism of the above passage made by the appellant and by the AIRE Centre largely relates to the second sentence. In relation, however, to the first sentence, they suggest that, irrespective of the precise meaning, in context, of “a significant reduction in life expectancy” in para 183 (as to which see para 31 below), the paraphrase of “death within a short time” favoured by the Court of Appeal may not be entirely accurate. In relation to the second sentence, their criticism is directed to the words “the imminence (i.e., likely ‘rapid’ experience) of … death in the receiving state” attributable to the non-availability of treatment. They point out that the Grand Chamber was addressing exposure “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” (italics supplied); and they contend that the Court of Appeal has misinterpreted those words so as to refer to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or in a significant reduction in life expectancy. The Secretary of State, for her part, rejects their criticism as narrow and syntactical, apt perhaps to the construction of a statute but inapt to the present context in which the meaning of para 183 should be informed by “case law and realism”. Her reference to case law turns out to be an indorsement of the questionable conclusion of the Court of Appeal that in the Paposhvili case the Grand Chamber approved its decision in the N case. What remains is her reference, rather undeveloped, to realism.

30. There is, so I am driven to conclude, validity in the criticism of the Court of Appeal’s interpretation of the new criterion. In its first sentence the reference by the Grand Chamber to “a significant reduction in life expectancy” is interpreted as “death within a short time”. But then, in the second sentence, the interpretation develops into the “imminence … of … death”; and, as is correctly pointed out, this is achieved by attributing the words “rapid … decline” to life expectancy when, as written, they apply only to “intense suffering”. The result is that in two sentences a significant reduction in life expectancy has become translated as the imminence of death. It is too much of a leap.

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.

32. The Grand Chamber's pronouncements in the Paposhvili case about the procedural requirements of article 3, summarised in para 23 above, can on no view be regarded as mere clarification of what the court had previously said; and we may expect that, when it gives judgment in the Savran case, the Grand Chamber will shed light on the extent of the requirements. Yet observations on them may even now be made with reasonable confidence. The basic principle is that, if you allege a breach of your rights, it is for you to establish it. But "Convention proceedings do not in all cases lend themselves to a rigorous application of [that] principle …": DH v Czech Republic (2008) 47 EHRR 3 , para 179. It is clear that, in application to claims under article 3 to resist return by reference to ill-health, the Grand Chamber has indeed modified that principle. The threshold, set out in para 23(a) above, is for the applicant to adduce evidence "capable of demonstrating that there are substantial grounds for believing" that article 3 would be violated. It may make formidable intellectual demands on decision-makers who conclude that the evidence does not establish "substantial grounds" to have to proceed to consider whether nevertheless it is "capable of demonstrating" them. But, irrespective of the perhaps unnecessary complexity of the test, let no one imagine that it represents an undemanding threshold for an applicant to cross. For the requisite capacity of the evidence adduced by the applicant is to demonstrate "substantial" grounds for believing that it is a "very exceptional" case because of a "real" risk of subjection to "inhuman" treatment. All three parties accept that Sales LJ was correct, in para 16, to describe the threshold as an obligation on an applicant to raise a "prima facie case" of potential infringement of article 3. This means a case which, if not challenged or countered, would establish the infringement: see para 112 of a useful analysis in the Determination of the President of the Upper Tribunal and two of its senior judges in AXB v Secretary of State for the Home Department [2019] UKUT 397 (IAC) . Indeed, as the tribunal proceeded to explain in para 123, the arrangements in the UK are such that the decisions whether the applicant has adduced evidence to the requisite standard and, if so, whether it has been successfully countered fall to be taken initially by the Secretary of State and, in the event of an appeal, again by the First-tier Tribunal.

14.
The above cases concerned a ppellants with physical health conditions. On 1 October 2019, in the Savran v Denmark 2019 ECHR 5746 7 /15 the European Court of Human Rights applied the Paposhvili test in cases involving the expulsion of a criminal with a psychiatric condition. R ichards LJ supported the application of the N test in psychiatric cases in RA (Sri Lanka) v SSHD [2008] EWCA Civ 1210 ; [2009] Imm AR 320 at [50] . This was endorsed by the same court in Y , which approved the six-part test in J , in suicide cases.

15.
Brooke LJ in J said it was possible f rom the case law to amplify the test and made 6 points. The fifth point was reformulated in Y .

16.

The J test, as formulated at [26] to [32] notes: -

“First the test requires an assessment to be made of the severity of the treatment which it is said that the applicant will suffer if removed. This must attain a minimum level of severity. The court has said on a number of occasions that the assessment of its severity depends on all the circumstances of the case. But the ill-treatment must ‘necessarily be serious such that it is ‘an affront to fundamental humanitarian principles to remove an individual to a country where he is at risk of serious ill-treatment’: see Ullah paras [38]-[39].

Secondly, a causal link must be shown to exist between the act or threatened act of removal or expulsion and the inhuman treatment relied on as violating the applicant’s Article 3 rights. Thus, in Soering at para [91], the court said:

‘Insofar as any liability under the Convention is or may be incurred, it is liability incurred by the extraditing contracting state by reason of its having taken action which has as a direct consequence the exposure of an individual to proscribed ill-treatment’ (emphasis added).

See also [108] of Vilvarajah where the court said that the examination of the Article 3 issue ‘must focus on the foreseeable consequences of the removal of the applicants to Sri Lanka …’

Thirdly, in the context of foreign cases, the Article 3 threshold is particularly high simply because it is a foreign case. And it is even higher where the alleged inhuman treatment is not the direct or indirect responsibility of the public authorities of the receiving state, but results from some naturally occurring illness, whether physical or mental. This is made clear in para [49] of D and para [40] of Bensaid .

Fourthly, an Article 3 claim can in principle succeed in a suicide case (para [37] of Bensaid).

Fifthly, in deciding whether there is a real risk of a breach of Article 3 in a suicide case, a question of importance is whether the applicant’s fear of ill-treatment in the receiving state upon which the risk of suicide is said to be based is objectively well-founded. If the fear is not well-founded, that will tend to weigh against there being a real risk that the removal will be in breach of Article 3.

Sixthly, a further question of considerable relevance is whether the removing and/or the receiving state has effective mechanisms to reduce the risk of suicide. If there are effective mechanisms, that too will weigh heavily against the applicant’s claim that removal will violate his or her Article 3 rights”.

17.
In Y the C ourt of A ppeal stated: -

“ 15. … The corollary of the final sentence of §30 of J is that in the absence of an objective foundation for the fear some independent basis for it must be established if weight is to be given to it. Such an independent basis may lie in trauma inflicted in the past on the appellant in (or, as here, by) the receiving state: someone who has been tortured and raped by his or her captors may be terrified of returning to the place where it happened, especially if the same authorities are in charge, notwithstanding that the objective risk of recurrence has gone.

16. One can accordingly add to the fifth principle in J that what may nevertheless be of equal importance is whether any genuine fear which the appellant may establish, albeit without an objective foundation, is such as to create a risk of suicide if there is an enforced return. ”

18.
Th e fifth point was reformulated as follows: -

“[…] whether any genuine fear which the appellant may establish, albeit without an objective foundation, is such as to create a risk of suicide if there is an enforced return . [15] ”

19.
Sir Duncan Ouseley in R (Carlos) v SSHD [2021] EWHC 986 (Admin) stated at [159]:

“ Article 3 and suicide risk: this is another facet to which Paposhvili and AM (Zimbabwe) apply. It is for EC to establish the real risk of a completed act of suicide. Of course, the risk must stem, not from a voluntary act, but from impulses which he is not able to control because of his mental state”.

20 . In sofar as the judgment in AXB v SSHD [2019] UKUT 397 relates to the procedural aspects arising from Paposhvili , what is state d at [112] (replicated at paragraph 3 of the headnote) was endorsed by the Supreme Court in AM :-

“ The burden is on the individual appellant to establish that, if he is removed, there is a real risk of a breach of Article 3 ECHR to the standard and threshold which apply. If the appellant provides evidence which is capable of proving his case to the standard which applies, the Secretary of State will be precluded from removing the appellant unless she is able to provide evidence countering the appellant’s evidence or dispelling doubts arising from that evidence. Depending on the particular circumstances of the case, such evidence might include general evidence, specific evidence from the Receiving State following enquiries made or assurances from the Receiving State concerning the treatment of the appellant following return. ”

2 1 . In respect of the obligations on the Respondent following Paposhvili , the Supreme Court stated at [33] as follows:-

“ In the event that the applicant presents evidence to the standard addressed above, the returning state can seek to challenge or counter it in the manner helpfully outlined in the judgment in the Paposhvili case at paras 187 to 191 and summarised at para 23(b) to (e) above. The premise behind the guidance, surely reasonable, is that, while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state. What will most surprise the first-time reader of the Grand Chamber’s judgment is the reference in para 187 to the suggested obligation on the returning state to dispel “any” doubts raised by the applicant’s evidence. But, when the reader reaches para 191 and notes the reference, in precisely the same context, to “serious doubts”, he will realise that “any” doubts in para 187 means any serious doubts. For proof, or in this case disproof, beyond all doubt is a concept rightly unknown to the Convention. ”

T he Appellant’s i mmigration h istory

22.
The Appellant claims to have entered the UK in 2006. The Secretary of State does not have a record of his entry. In 2011 the Appellant was arrested for attempted theft. He was remanded in Feltham Young Offenders Institute (YOI). He applied for asylum on 22 June 2011. On 14 September 2011 he was convicted of attempted theft. He was sentenced to nine months in a YOI.

23.

On 1 1 November 2011 his claim for asylum was refused. O n 5 December 2011 t he Appellant lodged an appeal against this decision. O n 19 December 2011 the decision was withdrawn by the Secretary of State . The application was again refused by the Secretary of State on 20 April 2012.

24.
The Respondent listed the Appellant as an absconder from 27 February 2013 until 19 March 2014. On 10 July 2014 the Appellant was convicted of robbery and ABH. On 29 August 2014 he was sentenced to 22 months ' imprisonment. A deportation order of 27 May 2015 was served on the Appellant on 5 June 2015. The Appellant made submissions on 23 July 2015 asserting that returning to the OPA would breach his rights under Articles 2, and 3 of the 1950 ECHR.

25.
On 25 November 2015 the Appellant made further representations seeking to revoke the deportation order. He relied on a medical report from Dr Elizabeth Clark of 18 November 2015 (AB/114-136) . He submitted that he was a victim of torture and that inconsistencies in his account can be explained by medical evidence.

26.
At the appeal before the First-tier Tribunal the Appellant relied on the evidence of Dr Clarke and Dr Arthur Anderson dated 6 April 2016 (AB/95-113) . Before us the Appellant relied on a psychiatric assessment by Consultant Forensic Psychiatrist Dr G alappathie dated 30 December 2020 (AB/12-47) and a report concerning the background evidence prepared by Professor Joff é dated 2 January 2021 (AB/48-94).

The b asis of the Appellant's p rotection c laim

27.
The Appellant ' s claim , in a nutshell , is that he fears return to the OPA because of imputed political opinion. His father was shot by the Israeli defence force because he was a spy for the Palestinians. The Appellant left Palestine when he was aged 11 and travelled to Egypt by lorry. He then travelled from Egypt to Turkey . In Turkey he was pursued by the people responsible for killing his family. He then travelled to Malta before coming to the UK by lorry.

The Respondent's d ecision

28.
The Respondent ' s case is that the Appellant is not credible. He is not from OPA. He is a national of Morocco. The Respondent relies on a linguistic analysis interview that was conducted on 4 November 2011 and dated 7 November 2011 (the Sprakab Report) and inconsistencies in the accounts given by the Appellant specifically in his asylum interview.

29.
T he Respondent relies on s. 8 of the Asylum and Immigration (Treatment of Claimants, etc.) Act 2004 concerning the delay in the Appellant having made a claim on protection grounds. The Appellant is excluded from protection of the Refugee Convention/grant of humanitarian protection because there are serious reasons for considering that he constitutes a danger to the community.

30.
The Respondent acknowledges that the health system in the OPA is not a on par with that in western countries ; however , there are organisations that the Appellant could approach there for help, support and assistance. In respect of Morocco , the Respondent ' s position is that the Appellant would

be able to receive sufficient medical treatment there . As will be seen below, the Respondent changed her position in post - hearing submissions . It is now conceded that if the Appellant is a citizen of the OPA, his claim should succeed under Article 3 (health grounds).

The h earing

31.
At the start of the hearing Mr Fu l lbrook indicated that the Appellant was able to give evidence in English, however it was decided that the interpreter would remain at the hearing to assist , if and when necessary. Ms Isherwood had not prepared a skeleton argument . We were surprised that in a case of such complexity, the Respondent had not thought it necessary to prepare a skeleton argument. What we had from the Respondent was an email with links to documents containing background evidence.

32.
During submissions we wanted Ms Isherwood to specify part s of the background evidence relied on and explain its relevance as regards health care in both OP A and Morocco. However, this put her in difficulty and the information was not readily forthcoming. This was frustrating for us. We thought it would assist us to give her the opportunity to do this in writing after the hearing and to give Mr Fullbrook the opportunity to respond.

33.
What we received in response were full written submissions presenting the Respondent’s case in a way which bear s little , if any , resemblance to the oral submissions we heard . It go es well beyond the information we sought. It is a blatant attempt to re-argue the case. It is obvious that the document should have been prepared for the oral hearing . To seek to rely on it after the hearing potentially undermines the function of the UT.

34.
There are two significant submissions now made that put the case on a different footing. Firstly, Ms Isherwood now concedes that the test in Paposhvili applies to mental health cases. She denied this in oral submissions. There is now a concession that the appeal should be allowed under Article 3, if the Appellant is found to be from the OP A . In oral argument she sought to persuade us otherwise. It is not accepted that there is a lack of medical treatment. The concession is made on the basis of “ uncertainty surrounding UNSC’s most recent recommendation at this current time. ” Secondly , submissions are made for the first time about how the approach in J should be reformulated following Paposhvili and AM .

35.
In response to Ms Isherwood’s written submissions , the Appellant has made further written submissions. It is submitted that the Respondent’s written submissions go well beyond the scope of the Tribunal’s direction and amount essentially to an attempt to re-argue the case. There is no reason why these submissions could not have been made at the substantive hearing. There is also no reason why the legal submissions contained therein could not have been made in a skeleton argument submitted before the hearing. The Appellant submits that it would be procedurally improper and unfair to the Appellant to admit these submissions since to do so (a) frustrates and undermines the purpose of oral arguments, and (b) creates additional costs contrary to the overriding objective.

36.

We take on board that Ms Isherwood was placed in the unenviable position of advancing a case which had not been prepared, and thus struggled to make submissions; however, the Respondent did not have the permission of the Tribunal to make full written post hearing submissions . They are significantly different to oral submission s. They rely on legal argument which Mr Fullbrook has not had the opportunity to respond to orally .

37.
It is incumbent on the parties to be ready to proceed to conclusion on the hearing date in furtherance of the overriding objective. Skeleton arguments should be produced prior to the hearing . There must be finality in litigation and the parties have a duty to be fully ready to conclude the hearing on the hearing date . Failure to be ready is contrary to Rule 2 of the Tribunal Procedure (Upper Tribunal) Rules 2008 ("the 2008 Procedure Rules") , with reference to the parties ' obligations to help further the overriding objective. [3] It is contrary to the principle of finality in litigation and raises issues of fairness , wasted costs and potentially wastes judicial time. If a party is not ready, any attempt to rely on post- hearing submissions, without the permission of the UT, should be resisted. It is an unsatisfactory way to conduct litigation.

38.
We deprecate the approach taken by the Secretary of State in this case. However, having considered the written submissions de bene esse , we note (i) they contain concessions in favour of the Appellant (ii) they contain for the first time coherent submissions on key issues we need to resolve (iii) Mr Fullbrook has been able to respond as outlined below and (iv) for the reasons set out below they do not result in a finding adverse to the Appellant. For those reasons we have been prepared to consider the submissions and do not find it necessary to reconvene the hearing.

<u>The evidence</u>

The Sprakab Report of 7 November 2011

39. The conclusions of the linguist who assessed the Appellant's language is that there is a very high certainty that his linguistic background is assessed to be north African, Moroccan. The following is stated in the summary of findings:-

"The speaker masters Arabic to the level of a mother tongue. The speaker does not speak any Palestinian variety of Arabic. The speaker's linguistic background is with a very high degree of certainty assessed to be in north Africa, in Morocco. The speaker's stated linguistic background is assessed to have a very low degree of probability".

40. The Appellant was said to speak "grammatically correct Arabic according to a variety spoken in Morocco". He uses words and expressions typical of north African Arabic in Morocco and examples of this are given. His language usage displays phonological features typical of a variety of north African Arabic spoken in Morocco; again examples are given.

The Appellant's evidence

41. The Appellant was unable to remember the contents of his two witness statements dated 22 August 2016 and 27 January 2021. The interpreter kindly agreed to assist the Tribunal by translating them to him. He then adopted the evidence as his evidence-in-chief.

42. The Appellant's most recent witness statement is in similar terms to the earlier one. The Appellant was extensively cross-examined by Ms Isherwood. He initially answered questions and then said he could not remember in response to further questioning.

43. The Appellant's evidence is that he was born on 1 January 1992 in Gaza. His father worked for the Israeli government. When he was 12 his parents and sister were shot and killed in their home. The Appellant witnessed this but successfully hid so that he was not discovered. He then ran to a neighbour's house. His grandfather was contacted. His grandfather took him to another town and then to Turkey. His grandfather left him with a family that he knew and told him that he could not return to Palestine. He remained in Turkey for a few months. He cannot recall how many. The people who killed his family tracked him down in Turkey. He does not know how the perpetrators found him. The Appellant had to leave Turkey. He escaped by bus and travelled to Malta. When in Malta he was able to travel to Italy. He remained in Italy for almost two years. During this time life was difficult because he did not have a home, family and he was destitute. He was attacked and shot in the leg. He still has scars from this.

44. The Appellant came to the UK in 2006. He did not claim asylum because he was scared, he did not know what to do. The Appellant has difficulty remembering dates.

45. The Appellant has not had contact with his grandfather since he left OPA. He does not know if he is still alive. Should he return to OPA he would be completely alone and have nothing.

46. He hears voices which tell him to harm himself. He has attempted suicide multiple times whilst in prison and after being released. He received some antidepressant medication in prison. It did not always help. He constantly felt depressed and anxious. The voices continued and got worse.

47. When he left OPA he was very young and all the Arabic speakers that he has spoken to have been from North Africa. He thinks he may have picked up an accent. He cannot remember much about his childhood and life in OPA because of his mental health problems and the difficulty he has concentrating. He does not know who killed his father, all he does know is that his family were killed because of his father's work with the Israeli government.

48. It is difficult for him to recall parts of his past and information was muddled in his head. When he was homeless, he did not have a GP and was not able to receive medication. When he was interviewed in 2011, he was not receiving medication for schizophrenia. He was very confused.

49. The Appellant has not fabricated a story. He is sorry for the crimes that he has committed here in the UK. When he was arrested, he was homeless and not receiving medication. Since he has started to receive proper treatment he now realises that his mental health problems made him unstable and contributed to his behaviour.

50. The Appellant was cross-examined. He was asked whether he had thought of going to the Red Cross to look for family members and he said that he had not. He said that he was frightened of everything and has been for years. He does not know whether his grandfather is still alive, he does not know his grandfather's name. His grandfather told him that his father was a spy. He has never thought about approaching an organisation to get death certificates for his family. He is not sure when his mental health problems started but he did hear voices before he left OPA. He did not agree with Ms Isherwood's suggestion that it was the voices that he hears in his head which account for the story about what happened to his family. His response was that the voices do not produce stories but encourage suicidal thoughts.

51. The Appellant does not remember how he travelled to Turkey or the family with whom he stayed. He said he does not remember his claim, despite the fact that his witness statements had been read back to him at the hearing. He denied being from Morocco and stated that he remembers his family being killed. He did not claim asylum when he arrived, he did not know what it was. He was afraid.

52. There was no re-examination.

Dr Clark's evidence

53. Dr Clark examined the Appellant and identified the following factors which she states are important in assessing risk of suicide and which are recognised as increasing a patient's suicide risk (see paragraph 6.11) and she listed them as follows:-

"• He has a clinical picture of severe depression and may also have PTSD.

• He has reported having suffered significant loss events as his parents and sister were killed.

• He states that he has no family, no friends and no social support.

• He has expressed hopelessness about the future as he said he has no future (research on hopelessness has identified hopeless thoughts as the biggest risk factor in predicting suicidal behaviour in individuals with depression).

• He has reported a past history of attempted suicide by hanging (a previous attempt is a recognised important factor, and use of a potentially effective method of suicide, such as hanging, is also suggestive of higher risk of future attempts). He also has evidence of self-harming (scarring on his left forearm).

• He has features of psychotic depression or other psychotic illness (although this needs further assessment) and it is known that risk of suicide is much higher in people with depression and psychotic symptoms than in those without psychosis, and also in people with schizophrenia."

54. In the same paragraph, the expert expresses concern that:

"… [the Appellant] is at significant risk of suicide, and that this could worsen if knew he (sic) were to be removed from the UK. It is relevant that he has said that the voices he hears are telling him to harm himself, which he might feel unable to resist if they become increasingly prominent when he is stressed. It is recognised in working with survivors of abuse that a subjective fear of further persecution tends to act as a 'stressor' and as a 'retraumatising' factor."

She states as follows:

"Since [MY] has expressed a subjective belief that others want to kill him, I am concerned that if removed from the UK, his mental state could deteriorate significantly. His depression, possible PTSD and psychotic symptoms could become more florid, and together with his hopelessness for the future could place him at significant risk of suicide. Should his removal become imminent I would recommend a reassessment of his mental state and suicide risk".

55. Dr Clark comments extensively on the Appellant's inconsistencies in the accounts that he has given and she states at paragraph 6.12 that the Appellant during the interview she had with him demonstrated some cognitive impairment. She said that there are a number of reasons why the Appellant may have reduced cognition and poor memory. She identifies the following:-

“(a) His stated history identifies a lack of education, and his current and previous level of intellectual functioning is difficult to determine. He has apparently not learned to speak English since arriving in the UK nine years ago (he said that he had some English lessons in Wandsworth Prison), although this may be because of his social isolation.

(b) Psychotic illness itself can lead to poor intellectual function e.g. due to distraction from hearing voices and due to negative symptoms of lack of motivation. Additionally poor concentration and variable or poor memory are features of depression and PTSD. It is known that memory can be variable and fluctuate with the severity of current mental symptoms, whether these are symptoms of depression or trauma related symptoms and also symptoms of psychosis.

(c) Theory and research suggests that very high levels of arousal are inhibitory in the encoding and retrieval of autobiographical memory of distressing events … the assumption that inconsistency of recall means that accounts have poor credibility is questionable. Discrepancies are likely to occur in repeated interviews.

(d) Another possible cause of his memory difficulties and impairment of thinking is head injury. In his stated history he described being repeatedly beaten, including being hit on the head in Ostend when he was unconscious and had a hospital stay of three days. He may have had a traumatic brain injury. Brain injury may have long-term effects on memory, difficulty processing information and emotional effects such as anger, which would accord with other symptoms he has described. As the Istanbul Protocol points out, it can be difficult to separate out the effects of head injury from the symptomatology of major depression and PTSD (see Istanbul Protocol chapter VI, para 249 – see note 5)”.

56. Dr Clark concludes that in her opinion it is “clinically plausible that difficulty in giving a consistent, detailed and chronologically ordered account may in [MY’s] case be due to the effects of his reported traumatic experiences and his mental state” (see paragraph 6.13).

57. Dr Clark at paragraph 6.14 considered whether the Appellant was feigning symptoms and stated:--

“… Found nothing to suggest that he was trying to exaggerate or feign any psychological distress. Additionally if someone wanted to fake serious psychiatric illness, I would expect them to put on more obviously bizarre behaviour rather than remaining calm and not agitated as [MY] did”.

58. It is Dr Clark’s opinion (see paragraph 6.16) that the Appellant needs a comprehensive psychiatric assessment to establish a diagnosis for his psychotic symptoms. He is more likely to receive comprehensive care for his mental health under community psychiatric services where he could be assessed, monitored and treated by a service such as “home treatment team” which could visit him frequently. In her opinion (see paragraph 6.17) the Appellant needs further assessment of his PTSD symptoms and if he is diagnosed with this treatment which according to NICE guidance involves comprehensive assessment with initial stabilisation and symptoms control followed by trauma focussed treatment with an experienced clinician.

Dr Anderson’s evidence

59. Dr Anderson is a Registered Consultant Clinical Psychologist. He recorded the results of psychological testing which we summarise. The Appellant has PTSD and schizophrenia., elevated levels of anxiety and consistent with witnessing the death of his family. He states that “his deterioration in mental state, his symptom constellation, and his avoidant behaviours in the presence

of what appears to be a formal thought disorder with paranoid delusions and self- harming tendencies are classic symptoms of schizophrenia". His main risk is related to schizophrenia and PTSD. As stress increases the effect of medication is reduced and symptoms return. This has drive him to live rough on the streets and contributed towards is acquisitive and violent behaviour. With appropriate medication and oversight his risk can be manged in the community. With sufficient medication and one to one counselling and/or psychotherapy, he will be more capable of coping.

60. He was assessed as being at high risk of violence to himself and moderate to others. "If managed appropriately with adequately supervised housing, psychiatric intervention, and an appropriate plan for a patient who suffers from two major mental health disorders, his symptoms and overall risk level should diminish rapidly."

61. There is no possibility of the Appellant falsifying his responses to the tests conducted.

Dr Galappathie's Evidence

62. Dr Galappathie is a consultant forensic psychiatrist. He conducted an examination of the Appellant on 24 November 2020. He took a record of the Appellant's history from what the Appellant said in his interview, past psychiatric history and information from health records and reports.

63. He made an assessment of the Appellant's recent progress and mental health at paragraphs 64 to 68. He commented on the Appellant's mental state at paragraph 71-73.

64. He expressed his opinion in answer to the specific questions asked of him by the Appellant's solicitors. His conclusions can be summarised as follows.

65. He presented as an individual suffering from severe depression, generalised anxiety disorder, Post Traumatic Stress Disorder (PTSD) and paranoid schizophrenia/psychosis. It is likely that his mental health problems as directly caused by his experiences of trauma within Gaza. He is likely to have developed PTSD as result of witnessing his parent's and sister being killed exacerbated by periods in detention. His mental health problems are consistent with his account of mistreatment. He requires treatment in the United Kingdom. He would benefit from ongoing follow up with his GP, anti-depressant medication, specialist psychological therapy. He will need stable accommodation and no fear of return to OPA in order to meaningfully engage with the therapy.

66. The prognosis depends on whether he can remain in the United Kingdom and is able to access treatment he requires. It is, however, limited by the severity and long-standing nature of his mental health problems and underlying psychotic illness. His symptoms are chronic.

67. His prognosis would be improved by his willingness to take antidepressant medication, the provision of stable accommodation, the availability of treatment and the ability to engage in that treatment.

68. Aggravating features in his case would be an uncertain immigration status, fear of being returned to OPA (or Morocco) and his psychotic illness which may impact upon his insight, motivation levels and ability to engage with Mental Health Services at times. Homelessness is also likely to be a significant factor that would adversely affect his mental health and prognosis.

69. Presently the Appellant is receiving treatment in the form of sertraline 50 milligrams per day, Zalwon XL 50 milligrams per day (antipsychotic medication containing quetiapine slow release), omeprazole twenty milligrams per day (anti-acid medication) and inhalers for asthma.

70. Inconsistencies in the Appellant's account could be explained by past trauma. PTSD is likely to have "significantly affected his memory and that any absence of information or inconsistencies in his history could be related to the trauma of the events that he outlines …". Psychotic illness by way of possible paranoid schizophrenia or underlying psychosis may impact on his ability to provide a consistent account. It is likely that his mental health problems have also had an adverse impact on his memory and ability to recall past event. It is undertstandable that the Appellant has signifcant problems with his memory and recall for past events.

71. The Appellant has reported thoughts about self-harm and suicide on a daily basis and thinks about cutting himself or ending his life. He reported a past history of self harm by way of cutting his abdomen with a piece of glass and attempting to hang himself while in prison (health records indicate that he reported suicidal thoughts in 2014 and attempted suicide in 2011 in HMP Wandsworth). It is likely that his suicidal thoughts are in relation to this past history of trauma, underling psychological distress and current mental health problems. It is likely that his fear of being removed to OPA or Morocco is causing him to have self-harm/suicidal thoughts. Such thoughts are exacerbated by his uncertain immigration status, worsening mental health problems, homelessness when this has occurred, isolation, lack of support, worsening mental health and fear of removal. The Appellant "presents with a high risk of self- harm and suicide" (see paragraph 128). He has a high number of risk factors (depression, anxiety, PTSD, paranoid schizophrenia or psychosis, history of trauma, homelessness, difficulty engaging with mental health services, past history of self-harm and on – going thoughts about self- harm).

72. If forcibly removed to OPA or Morocco, this is likely to lead to a worsening of his mental health problems by way of depression, anxiety and PTSD and will increase his risk of self-harm and suicide (see paragraph 130).

Professor Joffé's Evidence

73. Professor Joffé makes "three caveats to interpreting [the Appellant's] narrative, given the reservations that have been recorded with respect to it by the Secretary of State and an Immigration Judge".

74. He notes the evidence as to the Appellant's mental health and the impact on his ability to recall detail. He also indicates that the Appellant appears not to have any schooling at all and is presumably illiterate as a result. He says that this is surprising because Palestinians are generally amongst the most literate populations in the Arab world, pre-schooling starts at 4 years old and formal schooling at 6. He opines that in Morocco pre-schooling starts at 4 and compulsory schooling begins at 6 years old. Thirdly he states that despite the repeated contradictions in the various accounts of the Appellant's claims, some elements have remained consistent. He has repeatedly claimed that he was born on 1 January 1992 and lived in the refugee camp at Rafah in the Gaza Strip. He has also claimed that his father was killed by unknown assailants, together with his mother and younger sister, [S], because his father was accused of having been a collaborator with the Israeli forces in 2004. He was rescued by his grandfather after the shooting who took him for safety to Turkey but from where he eventually fled as the persons responsible for his parents and sister's deaths traced him there, so he travelled to Malta instead.

75. In relation to the Sprakab Report the assessment is that with a high degree of certainty the Appellant speaks Darija, the north African dialect of Arabic and not the Palestinian dialect as would have been expected had he come as he claims from the Gaza Strip. The Appellant has claimed in response that during his residence in Malta he was predominantly in the company of north Africans.

Mr Joffé concedes that he has no grounds to dispute the conclusions of the language assessment, however he says that he wonders if the Appellant's counterclaim should be summarily dismissed as he was after all only 12 or 13 years old and illiterate when he claimed to have been in Malta and children do tend to mould their linguistic styles to the social environment in which they are located.

76. At paragraph 121 he considers the Appellant's situation. He considers the Gazan health system at paragraphs 92 to 95. He considers health services in Morocco at paragraphs 99 to 106 and specifically psychiatric and psychological facilities at paragraph 107 to 110. He deals with psychosis and bipolar at paragraph 117 to 119.

77. In the light of the Respondent's position following written submissions, it is not necessary for us to consider health services in OPA. Professor Joffé engages with the health services in Morocco (Appellant's bundle 76/84). His evidence can be summarised.

78. He doubts that the Appellant would be in a position to receive anything approaching the same level of appropriate treatment that he has been receiving here. There are serious social implications associated with illnesses that should be taken into account.

79. Relying on an old Country of Origin Information Report (COI) of 9 November 2010, Professor Joffé states that the general picture of health provision is that adequate medical care is available in Morocco's largest cities particularly Rabat and Casa Blanca although not all facilities meet high quality standards. Most ordinary prescription and over the counter medicines are widely available. There are wide disparities between the public and private sectors. The state sector provides healthcare free at the point of delivery although hotelling charges were introduced in the 1980s. It consists of basic healthcare. The Appellant would not be eligible for funded treatment in the state sector unless he were in employment and would therefore have to pay for whatever treatment he received from its facilities. State provision is inadequate. The situation has worsened over the past decade. Mental health provision is far more limited. Moroccan families are particularly badly provided for.

80. In relation to psychosis and bipolar disorder Professor Joffé states that there is very limited information available on these disorders. In the public sector there is a critical shortage of psychiatrists or mental health workers, there is not an adequate infrastructure with only three centres capable of providing treatment in Casablanca, the country's most popular city, and only 30% to 40% of all physicians trained to respond to mental health issues. Often antiquated facilities have closed and have not been replaced.

81. The Appellant could not expect to access in Morocco the drug regime to which he is now habituated. He could not anticipate anything similar to the kind of hospital treatment and care that has been available to him. He could not afford the cost of the private sector. State-provided medical services in Morocco are rudimentary by British standards and social services are extremely limited too. The only treatment available to the Appellant would be recourse to the traditional medical sector which still plays a dominant role in Morocco.

Submissions

82. Ms Isherwood did not provide a skeleton argument or written submissions until after hearing. Mr Fullbrook relied on a skeleton argument at the hearing. He has submitted further written argument, in response to the Respondent's post hearing submissions.

83. We will seek to summarise the main points made by the parties. This was not as straight forward as it should have been because the Respondent's written submissions were different to the oral submissions on material matters.

84. In oral submissions, Ms Isherwood relied on exclusion. She did not make detailed oral submissions and did not refer to the issue in written argument.

85. In respect of the test to be applied, Ms Isherwood's oral submissions sought to persuade us that Paposhvili and AM do not apply to mental health cases and that the N test applied. However, her written submissions concern how AM should be considered in the context of Article 3 in mental health cases, emphasising that the court did not accept that the meaning of "a significant reduction in life expectancy" could be anything but "substantial". Neither did the court accept that there was a strict requirement on the SSHD to prove that such medication in the receiving state would be available. The burden to do so remains on the Appellant to prove that it would not.

86. In written submissions the Secretary of State asserts that it is clear that while Y , J and Bensaid v United Kingdom 2001 ECHR 44599/98 relied on the application of the N threshold as opposed to the now modestly extended protection of AM , nonetheless in psychiatric cases the focus has always been on the treatment or lack of it in the receiving country and the impact that would have on the person. J and Y test remain good law. This was touched upon in oral submissions; however, a wholly new argument was advanced in written submissions. Ms Isherwood proposed the following reformulation of the sixth part of the J test in the following way: -

"Whether the removing and/or the receiving state has effective mechanisms to reduce the risk of psychotic relapse which could expose the person to serious, rapid and irreversible decline in their state of health resulting in intense suffering and/or substantial harm to themselves or to others".

87. A further issue raised for the first time in the post hearing submissions is the endorsement of a seventh principle to include the guidance provided by the Upper Tribunal in AXB at [123]– [125], as reflected in [112]–[117] of the same; endorsed by the Supreme Court in AM at [32].

88. The Secretary of State summarises its position in the post hearing submissions in this way: -

(a) The obligation is on the applicant to raise a "prima facie case" of potential infringement of Article 3. The burden being on them to prove that there are substantial grounds for considering, that theirs is a very exceptional case because of a real risk of subjection to treatment, resulting from the foreseeable consequences of the removal [AM at [32]; [108] of Vilvarajah and Others v United Kingdom 1991 ECHR 13163/87] .

(b) The obligation on the authorities of a returning state dealing with a health case is primarily one of examining the fears of an applicant as to what will occur following return and assessing the evidence [AXB at [123]].

(c) There is no freestanding obligation on a returning state to make enquiries to the receiving state concerning treatment or obtain assurances in that regard [AXB at [124]]. Once a prima facie case is established that in accordance with AM at [33] the Secretary of State is not obliged to dispel "any doubts" raised by the applicant's evidence.

89. In respect of the Sprakab evidence, Ms Isherwood brought to our attention to the fact that the Appellant had not requested a transcript of the Sprakab interview. She urged us to attach weight to the Sprakab Report. In respect of Dr Joffé evidence, she said that he is not a language expert or

analyst. In written submissions, Ms Isherwood develops this point referring to the Appellant's continued assertion that the findings in the Sprakab Report results from his interaction with friends who are of Algerian descent. The Secretary of State submits that this does not plausibly address the report which specifically points to a Moroccan dialect and not Algerian. Secondly, the lack of supporting evidence from friends supporting this contention, is a clear indication that it is not a credible reason. This is further undermined by the ample opportunities the Appellant has had to provide such evidence given the length of time since the Respondent's first decision asserting the nationality dispute and the extensive appeal process resulting.

90. She submitted that the Appellant was evasive when giving evidence. He did not answer the questions posed by the Secretary of State's representative and merely relied on his inability to recall events due to the passage of time. He said he could not remember what was in his witness statements although he had just had them read to him. She submitted that the Appellant is from Morocco. There is no evidence that the Appellant has current treatment for mental health issues. There are inconsistencies in the Appellant's account. He was unable to answer questions before the Upper Tribunal, however he was able to answer questions when interviewed and to various experts.

91. Ms Isherwood noted that Dr Galappathie's evidence is silent on the impact of the Appellant's mental ailments on his long-term memory, preferring to support the contention that his short-term memory capacity is "good" [AB/27 at 71]. Neither does the report suggest that the trauma suffered, or his mental health more generally are capable of negating his ability to give evidence. It is not unreasonable for the Secretary of State to expect the Appellant to have given less evasive evidence. While evasiveness on its own does not amount to implausibility, looking at the evidence in the round, notably; the lack of reasoning for not explaining the Sprakab findings and why they should not be followed along with the Appellant's alleged illiteracy being at odds with the external evidence from Professor Joffé undermines the Appellant's evidence [AB/52 at 1]. It is submitted that on the balance of probabilities the Appellant is a national of Morocco and not from the OPA.

92. A concession is made for the first time in the written submissions. At the hearing before us, Ms Isherwood argued that treatment would be available to the Appellant in OPA and to return the Appellant there would not breach the United Kingdom's obligation under Article 3. She had difficultly in drawing our attention to specific background evidence. The issue is now otiose. In written submissions, it is now conceded that that "in this instance, considering the uncertainty surrounding UNSC's most recent recommendation at this current time, that returning MY to Gaza would amount to a breach of the Secretary of State's obligations under Article 3 of the European Convention on Human Rights". There is no clear and detailed explanation given of the basis of the concession. However, this is not an issue we need to engage with.

93. In oral submissions, Ms Isherwood drew our attention to paragraph 126 of Dr Galappathie's report which says that there is a significant history of self-harm, however, she said that there are no details given (in written submission it is conceded that the Appellant has made suicide attempts in the past). She referred to Dr Clark's report. She said that it represents the overall position in 2015 and therefore not much weight can be given to it. However, she then accepted that she could not get around what Dr Galappathie says about suicide attempts and the Appellant's rapid decline.

94. In written submissions, the Secretary of State accepts that the Appellant is diagnosed with schizophrenia and that he has PTSD. However, it is submitted that the Appellant has failed to demonstrate that the severity of the treatment would lead to serious irreversible harm. While the Secretary of State does not dispute attempted suicide in the past or that the risk of suicide would

increase if he knew he was going to be removed, the medical reports from Dr Clark and Dr Anderson are said to show that the Appellant's condition will improve if he were to access the cognitive therapy recommended and the reports further submit that his mental health will stabilise with the assistance of medication.

95. In the written submissions it is accepted that the Appellant is receiving medication; however, there is no evidence to support that he has accessed treatment advised by specialists. This, according to the Respondent, demonstrates that his mental health is stable and that he has not suffered a psychotic relapse and/or heightened suicidal ideation and that medication has enabled him to carry on with everyday activities despite the additional treatment or therapy. This is significant as immigration uncertainty can often be a key factor impacting a person's mental health. Therefore, it cannot be said that his current mental health meets the seriousness threshold of J and Y.

96. In written submissions, reference is made to background evidence concerning Morocco and submissions made relating to it. It is argued that the Appellant has not provided the Tribunal or the Secretary of State with an explanation why he would be in genuine fear of returning to Morocco. There are clearly adequate medical care and facilities capable of treating and addressing the Appellant's medical condition in Morocco, this includes access to psychiatrists, mental health hospitals and provincial medical centres (see Professor Joffés report at 101, 107, 110 and 116). This is further supported by IOM's 2016 country fact sheet (Response to an Information Request Morocco: Treatment for mental health, dated 1 November 2018) which notes: -

"The Moroccan health system is generally well developed and well run in the cities, while the countryside is less well equipped. Cities also have private hospitals offering high quality services. The facilities in Moroccan hospitals outside the cities are generally basic and old fashioned. However, the medical care is of quality. Since recently Moroccan hospitals are modernising and purchasing specialised equipment to be able to provide superior treatment".

97. In addition to that the MA MedCOI response, reference BMA 9581 dated 17 May 2017 confirms that there are short-term psychiatric clinical treatments available. This includes both outpatient and inpatient facilities which can be accessed in both private and public hospitals. The report further confirms the availability of non-voluntary admissions to the Ar Razi, Rue Ibn Rochd Salé Hospital which is a public facility.

98. It is accepted that due to the COVID pandemic, health services globally have been strained by the increased admissions of patients requiring ICU assistance. However, the Secretary of State avers that there is no evidence to suggest that this has depreciated Morocco's capability of treating psychiatric illness.

99. The Appellant has stabilised his health with the assistance of sertraline, Zalwon and omeprazole, which are available in Morocco according to the MedCOI reference BMA 9581, dated 17 May 2017.

100. In oral submissions, Ms Isherwood stated that in relation to Article 8 that there was no evidence of private life. She did not accept that Article 8(1) was engaged. In written submission, the Secretary of State avers support for the Court of Appeal's position in GS (India) v SSHD [2015] EWCA Civ 40; [2015] Imm AR 608 . It cannot be said that the Appellant is someone whose condition has been partially stabilised by the external factors existing in his private or family life established in the UK. Neither can it be said that his condition incapacitates his ability to engage with the wider community or to form and enjoy relationships.

101. Mr Fullbrook relied on his skeleton argument at the hearing. We indicated at the start of his submissions that we were satisfied that the Appellant should not be excluded from the Refugee Convention. He did not need to address us on that point.

102. The Appellant relies on AM (Afghanistan) v SSHD [2017] EWCA Civ 1123; [2017] Imm AR 6 . Ryder LJ set out a ("not exhaustive or immutable") list of principles for the determination of asylum and protection claims (see [21]). He drew our attention to these. [4]

103. In respect of the Sprakab Report the Appellant submits that the negative assessment of his credibility is misplaced for the following reasons: -

(1) The Appellant suffers from severe depression, PTSD, generalised anxiety disorder and paranoid schizophrenia. Consultant forensic psychiatrist Dr Galappathie has confirmed that these conditions would have an impact on the Appellant's memory and ability to recall past events, especially traumatic ones. Careful and specific attention should be paid to every aspect of such medical reports, see Ibrahim v Secretary of State for the Home Department [1998] INLR 511.

(2) The Sprakab Report results are inconclusive. The Appellant has explained he may have picked up a North African accent because he has spent time with North Africans from a young age. Professor Joffe has also provided helpful observations of the report. Furthermore, the Supreme Court in N v Advocate General for Scotland [2014] UKSC 30; [2014] Imm AR 981 warned against assuming that Sprakab Reports provide certainty and stress the need to examine them critically in the context of all the available evidence.

(3) The Appellant's account is supported by Dr Galappathie who states that his symptoms are likely to have been directly caused by the Appellant's past experiences of trauma and are consistent with his account of mistreatment. The Appellant has explained that he will be killed if he returns to OPA. His fears continue to deeply affect him. The Appellant has also explained that the people who killed his family tried to find him and kill him in Turkey. If this is the case, then the Appellant plainly will not benefit from sufficient protection in the Gaza Strip particularly given his family's alleged association with the Israeli state and the general lack of protection there indicated in the Respondent's own guidance (CPIN December 2018).

104. He drew our attention to Savran v Denmark in which the majority decided that the decision in Paposhvili applies to mental health cases and nothing in AM (would suggest otherwise. He also relied on the case of R (Carlos) v SSHD . There is no evidence that the Appellant is feigning illness, he is at a high risk of suicide and the test in AM is met. He relied on the evidence of Professor Joffe about the state of mental health services in OPA. The Appellant's current treatment here is medication, he has follow-up appointments with his general practitioner. The test is as set out in Paposhvili and confirmed by the Supreme Court in AM .

105. The Tribunal must ask itself 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. That this judgment applies to cases involving mental illness and risk of suicide has been confirmed by Sir Duncan Ouseley in R (Carlos) v SSHD . It is for the Appellant to demonstrate that there are substantial grounds for believing that such a risk exists; after that point, the burden falls to the Secretary of State to "dispel any doubts raised by it".

106. He drew our attention to paragraph 72 of Dr Galappathie's report evidence and paragraph 9 of Dr Clark's report. He relied on the Appellant's consistency in his evidence in relation to what he fears on return to OPA, namely the people who killed his family. Dr Galappathie has found that he currently presents with "a high risk of self-harm and suicide" and that, if returned either to Morocco or the OPA he is likely to present with "an immediate and high risk of self-harm or suicide". It is clear that this risk will arise as a result of his removal and regardless of the availability of any treatment in the receiving states. The Appellant has plainly demonstrated substantial grounds in this case.

107. Even if the availability of treatment were relevant, Mr Fullbrook submits it is clear that such treatment will be insufficient to alleviate the risk of death or intense suffering arising from the Appellant's mental illness. Professor Joffé has described mental health treatment in the OPA as "dire" and pointed to "a desperate shortage of mental health specialists". Professor Joffé has also described the availability of public health facilities for individuals with the Appellant's serious mental health disabilities to be "inadequate" and private facilities would not be affordable.

108. Mr Fullbrook's overarching submission is that deporting the Appellant to the OPA would lead to death or serious injury at the hands of those who killed his family which would contravene Articles 2 and 3 ECHR, and that returning him to Morocco or the OPA would result in breach of his Article 3 ECHR rights on health grounds which would serve as a bar to removal regardless of whether the Tribunal finds his account to be credible or not.

109. In his written submissions in response to Ms Isherwood's post hearing submissions, Mr Fullbrook's primary submission is that they are not admissible. However, in the alternative, they are rejected. He submits the correct test for mental health/suicide cases is now as set out in Paposhvili an d confirmed by the Supreme Court in AM. This test, adapted to this particular context is whether there are substantial grounds for believing that 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 his mental health resulting in intense suffering, or

(ii) a significant, meaning substantial, reduction in his life expectancy arising from a completed act of suicide.

110. In support of this submission, Mr Fullbrook makes reference to the Supreme Court in AM having made no distinction between mental and physical cases. No principled distinction exists: RA . The Appellant relies on Savran v Denmark and Carlos and on the fact that the Supreme Court endorsed AXB in terms of the Tribunal's treatment of the procedural requirements of Article 3, not in terms of the threshold test applied. Once the Appellant has established the substantial grounds then it is for the Respondent to dispel "any serious doubts" (see AM [33]).

111. He reiterated his submissions that it is of no surprise given the unchallenged medical evidence before the Tribunal that the Appellant struggled to respond to questions put to him about his past during a lengthy cross-examination. The Tribunal is invited to find, as a matter of fact the Appellant is from OPA.

112. The Appellant cannot be returned to Morocco because he is not Moroccan. Notwithstanding this, Mr Fullbrook highlights the fact that, contrary to what is asserted in the Secretary of State's written submissions, Dr Galappathie findings are that the Appellant currently presents with "a high

risk of self-harm and suicide" [A/40] and that, if returned either to Morocco or OPA he is likely to present with "an immediate and high risk of self-harm or suicide" [A/41] regardless of the availability of any treatment in the receiving states. This evidence plainly demonstrates the "substantial grounds" test.

113. To the extent to which the Tribunal considers evidence of the availability of treatment in the receiving states to be relevant, the evidence upon which the Respondent relies is said to be plainly inadequate. It is out of date and predates the outbreak of COVID-19 which will (as the Respondent acknowledges) have a material effect. It does not dispel "any serious doubts". For instance, a document submitted by the Respondent entitled Response to an Information Request Morocco: Treatment for mental health, is dated 01.11.18 and is based on reports from as long ago as 2017. In discussing the availability of health treatment, the document mentions (see 4.1.1) just one public facility (Hospital Ar Razi, Rue Ibn Rochd) and concedes (in the MedCOI disclaimer) that "it does not provide information on the accessibility of treatment". The document also concedes (see 3.1.1) that it "can only provide limited information on the cost of healthcare or medication".

114. In contrast, the Appellant relies on the up-to-date report of Professor Joffé who has described the availability of public health facilities for individuals in Morocco with the Appellant's serious mental health disabilities to be "inadequate" and stated that private facilities would not be affordable. The Tribunal is invited to read the evidence in full.

115. It is conceded that return to OPA would breach the UK's obligations under Article 3. However, it is not correct to say that there is "no evidence to suggest that general healthcare provisions in OPA are not adequate". There is considerable evidence of this in Professor Joffe's report [see, for example, A/74]. Indeed, even the Respondent's own evidence entitled Report of the Home Office Fact-Finding Mission Occupied Palestinian Territories: Freedom of movement, security and human rights situation, describes mental health in OPA as "a big concern" ([see 4.24.8] and as having "severe capacity gaps" [see 4.24.14].

116. The Appellant has given evidence of a private life in the UK. He has learnt to speak English and has established a number of friendships including with an individual who supported him in attending the hearing.

Discussion

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.

118. There is nothing in European or domestic case law to support any contention that Paposhvili does not apply to suicide cases. Contrary to her oral submission, Ms Isherwood in written submissions accepts it applies. That Paposhovili applies to cases involving mental illness and risk of suicide, was confirmed in Savran v Denmark and again recently by Sir Duncan Ouseley in Carlos .

119. The Respondent relies on Y and J . The Respondent submits that they still apply but proposes a modified sixth point. Mr Fullbrook in his response states that the correct test is set out in Paposhvili a nd confirmed in AM . We agree. However, in our view, insofar as J and Y concern subjective fear on

return, we find that the guidance is still valid. There is nothing controversial about points 1-4. What is stated therein has not been overtaken by AM.

120. We reject Ms Isherwood's submission that there is a threshold test in either J or Y . The 6 points made are not a test. They amplify the test set under Article 3 in the light of N ('the N test'). Furthermore, the Secretary of State now accepts that the correct test is that in Paposhvili and AM . In so far as Ms Isherwood seeks to introduce a further burden or test on the Appellant arising from Y or J by reformulating point 6, we reject this. Ms Isherwood's reformulation of point 6 is an attempt to create a threshold test which has no basis in law.

121. Points 5 and 6 give guidance on how to deal with subjective fear. While the guidance specifically refers to suicide cases, this simply reflects the N test. In order to reflect properly the applicable Paposhvili test, the guidance should now apply to mental health cases generally where fear is unfounded.

122. Moreover, the final sentence of point 5 is not an attempt to create any extra burden on the Appellant in a suicide (or mental health) case. The point made by the Court of Appeal in J must be considered in context. The Appellant in that case did not have psychosis or schizophrenia. He had PTSD from what had happened to him in Sri Lanka. There was treatment available in Sri Lanka to which the Appellant would have access because he had the support of family members. Moreover, in Y , the Court of Appeal added to point 5 something of particular relevance to this appeal, namely that what may be of equal importance is whether any genuine fear which the appellant may establish, albeit without an objective foundation, is such as to create a risk of suicide if there is an enforced return.

123. The six points in J apply to mental health cases post Paposhvili . They do not impose a test or a burden on an appellant. They are guidance on how to deal with subjective fear.

124. The Appellant must adduce evidence capable of demonstrating that there are substantial grounds for believing that Article 3 will be violated. This can be explained as raising a prima facie case which means a case which in the absence of challenge would establish infringement. It is a demanding threshold. It is for the Appellant to demonstrate that there are substantial grounds for believing that such a risk exists; after that point, the burden falls to the Secretary of State to dispel any serious doubts raised by it (AM [33].) We reject Ms Isherwood's submission on the point on her proposed suggestion of a seventh point. While the Supreme Court rejected the submission that there is an obligation to dispel any doubts, they interpreted the decision of the Grand Chamber as intending to oblige the Respondent to dispel serious doubts. In any event, this is another attempt to introduce and threshold test, which is unnecessary. The test is set out in Paposhvili and AM .

Findings and reasons

125. We communicated our decision in respect of the exclusion point at the hearing, having heard Ms Isherwood's very brief submissions on the issue. We find that the Appellant has not been convicted of a particularly serious crime and he does not constitute a danger to the community. The presumption does not apply in his case because he has not been convicted of a sentence of imprisonment of two years or more.

126. There is no meaningful challenge to the medical evidence before us. The Appellant has a history of significant mental illness. In 2015 he was assessed by Dr Clark as presenting a significant risk of suicide and as having a subjective belief that others want to kill him. A year later the Appellant

was assessed by Dr Anderson who assessed him to be at high risk of violence to himself. He said that his symptoms would diminish rapidly if managed appropriately. The most recent medical evidence confirms diagnoses of severe depressive episode, generalised anxiety disorder, PTSD and paranoid schizophrenia/psychosis and states that he is at high risk of self-harm. His symptoms are chronic. He has a history of self-harm and takes medication. In the most recent medical evidence, Dr Galappthie expresses a more pessimistic outlook than Dr Anderson about the Appellant's prognosis even if he is allowed to remain here (prospects for improvement are limited by the severity and long- standing nature of his mental health problems and underlying psychotic illness).

127. We attach weight to all the medical evidence. We consider the evidence applying the Joint Presidential Guidance Note No 2 of 2010 and what the Court of Appeal stated in AM (Afghanistan) .[5] This Appellant is vulnerable and credibility should be assessed with this in mind.

128. Much was made of the Appellant being evasive when cross-examined suggesting that this undermined his credibility. We take into account that Dr Galappathie has stated that the Appellant has a reasonable short-term memory; however, at paragraphs 114 and 115 of his report he stated that inconsistencies in the Appellant's account could be explained by past trauma and that it is likely that his mental health problems have had an adverse impact on his memory and ability to recall events. The Appellant did not answer questions when cross-examined by Ms Isherwood. He said that he could not remember, having just had his witness statements read back to him. On the face of it, this does not sit particularly well with his ability to give Dr Galappathie an account in December 2020 and to other experts. However, we bear in mind the Appellant's medical conditions and vulnerability. He was extensively cross-examined by Ms Isherwood. It was put to him that the murder of his family may be a delusion. In any event, we do not consider evasiveness under cross-examination undermines his credibility. Indeed, considering the medical evidence, we are surprised that he gave live evidence. We also take into account that most of the evidence in his witness statements set out the Appellant's immigration history, a factual background which appears to have been lifted from the decision letter.

129. We accept that there are significant discrepancies in his evidence, with particular reference to what the Appellant said when interviewed. He has been inconsistent about who was responsible for atrocities and for whom his father worked. We accept that the Appellant's memory is impaired for the reasons identified in the medical evidence. We accept considering the medical evidence and that events happened some time ago when the Appellant was a child, it would be surprising if this Appellant gave a detailed and coherent account. What the evidence before us does clearly establish is that this Appellant has been deeply traumatised by an event/events in his lifetime. He has always been consistent about having witnessed the murder of his family. We accept this aspect of his evidence. The medical evidence establishes a clear link between past trauma/mistreatment and his mental illness.

130. The main problem with the Appellant's evidence is that it is lacking in detail. We accept that there are very good reasons why the Appellant has not given a detailed or consistent account. However, taking into account the evidence as a whole, including the Sprakab report, properly applying the lower standard of proof we find that there is insufficient evidence that he is from OPA. We find that the Appellant is Moroccan. He may well have been in OPA at some stage in his early life. We accept that he may believe that he is from OPA. However, in respect of the issue of the Appellant's nationality, taking into account his mental health conditions, his age and vulnerability and the evidence as a whole, we find that he has not established that he is from OPA. We find that he is not a reliable witness and that the account that he has given about his nationality is not credible. Taking into account his serious mental health problems, he may not have intended to mislead the Tribunal, but the evidence he has given is not sufficient to discharge the burden of proof. However, if the

Appellant is knowingly misleading the Upper Tribunal about his nationality, we accept that ultimately this is not fatal to his claim to be at risk on removal to Morocco on Article 3 health grounds. However, the Appellant's claim appeal on protection grounds is dismissed.

131. In reaching conclusions about the Appellant's nationality, we attach weight to the Sprakab report. It is not determinative of the issue; however, our attention was not drawn to anything capable of undermining the conclusions in a meaningful way. We do not attach weight to the Appellant's lack of knowledge of Gaza considering the young age he states that he left. However, the author of the Sprakab Report was aware that the Appellant's claim is that he left Gaza at a young age (he stated to her that he left aged 9). We reasonably infer that the conclusions reached by the expert take this into account. Her conclusions are unequivocal.

132. We have taken on board what Professor Joffe has stated about the Appellant mixing with North Africans and having left Gaza at an early age, however Professor Joffé is not a linguist. In so far as his evidence concerns the Sprakab report, we attach limited weight to it. We have no evidence explaining how and to what extent, if any, the evidence of the Appellant having mixed with North Africans would undermine the conclusions in the Sprakab report. The author was aware that on the Appellant's own account he had not been in OPA for some time. The Appellant, who has been represented throughout the protracted proceedings, has not instructed a linguist. The author of the Sprakab report was aware of the history concerning the Appellant having left OPA at an early age (he told her that he was aged 9). While there is no requirement for corroboration, we take into account that the Appellant has instructed a number of experts throughout the proceedings, and it was open to him to instruct a linguist to assess his language and to comment on the Sprakab report. Considering the totality of the evidence, we conclude that it is reasonably likely that this Appellant is Moroccan. We accept that the Appellant may believe his own account, but we are unable on the evidence to accept everything that he says.

133. We attach significant weight to the Appellant having been a child when he witnessed the traumatic event/events and fled his home country. We find that he has no clear recollection of events. His recollection is further undermined by his mental health problems. The evidence points to him having witnessed traumatic events, not only the murder of his family, but as someone who has been destitute and homeless with mental health problems. We note that he had a head injury from being assaulted in Ostend, which may according to Dr Clark have been caused a brain injury.

134. The Appellant has given an account of travelling to Turkey and through Europe. While, we do not necessarily accept the route, we have no reason to disbelieve his account of a lengthy and protracted journey passing through several countries.

135. We accept that he does not have family who are in a position to help him in Morocco or anywhere. The evidence points to the Appellant being very much alone in the world. He mentioned a grandfather who helped him to travel to Turkey. However, we are satisfied that he does not have contact with any member of his family who is able to offer him any meaningful support. We take into account that the Appellant has endured destitution, serious mental illness and ill-treatment since leaving his home country. This would support that he either has no family or there is no family member able and willing to help him.

136. We do not accept that the perpetrators of the crime against his family have any interest in pursuing the Appellant. However, the medical evidence leads us to conclude that the Appellant has a genuine belief that they pursued him and located his whereabouts when in Turkey. We find that the

Appellant has a subjective fear that those who are responsible for killing his family pursued him to Turkey and continue to pursue him.

137. The Appellant is assessed as presenting a high risk of self-harm and suicide (see paragraph 128 of Dr Galappathie's report) and that should he be forcibly removed to OPA or Morocco this is likely to lead to a worsening of his mental health and increased risk of self-harm and suicide (see paragraph 30 of Dr Galappathie's report). The medical evidence is that detention would lead to an acute psychotic relapse. On return to OPA or Morocco the Appellant is likely to suffer from worsening psychotic symptoms and present with an immediate and high risk of self-harm and suicide. It is significant that the medical evidence makes no distinction between risk on return to OPA or Morocco. We accept this because the Appellant believes that he is actively being pursued by those who killed his family and therefore the fear exists wherever. Moreover, the evidence is that the Appellant struggles to engage with health services when he is homeless. We accept that the Appellant as a result of trauma and psychosis/schizophrenia, hears voices telling him to kill himself.

138. We do not accept that the Appellant has not explained why he fears return to Morocco as asserted by Ms Isherwood. This ignores the medical evidence. The Appellant's case has been advanced on the basis that he believes that he is being pursued by those who killed his parents. He believes that they pursued him to Turkey. He is at high risk of suicide. Moreover, he would not in our view be able to engage with the limited health care available in Morocco to allay his fears.

139. Although he is at present not receiving treatment recommended by Dr Galappathie save medication that may be available (or similar) in Morocco, he has from time to time had access to treatment and sees his GP. We do not accept the submission that his condition can be described as medically stable. He is at high risk of self – harm and his condition is chronic. His condition will deteriorate on removal to Morocco because the Appellant has a subjective fear that he is being pursued by the people responsible for his family's death and hears voices telling him to kill himself. We are satisfied that he will be arrive in Morocco alone, without support. He is likely to be destitute. He believes he is being pursued. This must be considered in the context of him already presenting a high risk of self-harm.

140. The medication he receives here and visits to his GP have no doubt prevented the Appellant from making any recent attempts on his own life. Having accommodation is a feature that has helped him engage with mental health services. In respect of availability of medical treatment in Morocco, we attach weight to Professor Joffé's clarification of the background evidence relied on by the Respondent. There was no meaningful challenge to this. While we accept that there are some medical facilities in Morocco which if accessed are capable of offering some treatment, we attach weight to the evidence of Professor Joffé that mental health facilities are likely to be inadequate. We find that private facilities would not be affordable to the Appellant. We find that the medical evidence establishes that the Appellant is at risk of self-harm or suicide which we find would materialise as soon as he arrives in Morocco because there will be no support to enable him to access the limited facilities available (though there is no requirement for imminent death properly applying the Paposhvili test).

141. The evidence does not establish that medical facilities and treatment in Morocco will alleviate the immediate and high risk of self-harm or suicide that the Appellant presents. To the extent that treatment might be available, it would certainly not be accessible to this Appellant. We take into account that destitution and poverty are factors that have exacerbated the Appellant's mental health problems in the past and have also hindered his ability to access medical help in the United Kingdom.

His engagement with health services here has been haphazard. It is reasonably likely that he will face destitution and poverty in Morocco. At present the Appellant has accommodation here and there is some engagement with health services. Without any kind of support network, family or accommodation, it is unlikely that he will be able to access any kind of health care, state provision of private.

142. We do not accept the Appellant's case that medical provision is irrelevant because although he has a high risk of suicide here, he has not made recent attempts because he has some support from his GP and the availability of medication is very accessible. When he is accommodated and supported, he is at less risk of harming himself, albeit the risk is high. With the relatively low level of support here, the risk remains high. It will be critical with limited health services and no support to help him access these.

143. We take into account the high risk of suicide, daily suicidal thoughts and attempts on his life as documented by Dr Galappthie. We attach weight to the fact that the Appellant hears voices. While the uncertainty of removal is not helping him and is a factor affecting his mental health it is not the key factor. The Appellant has established that he has a genuine fear, albeit without an objective foundation. That fear is such as to create a risk of suicide if there is an enforced return to Morocco.

144. We are in no doubt that the evidence before us raises a prima facie case of potential infringement of Article 3. Properly applying Paposhvili , the Respondent's background evidence relating to Morocco and health care provision does not dispel serious doubts raised by the Appellant. The Appellant has established that there are substantial grounds for considering that this is an exceptional case because of a real risk of subjection to inhuman treatment resulting from the foreseeable consequences of his removal. He 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 a serious, rapid and irreversible decline in his state of health resulting in intense suffering and a significant, meaning substantial, reduction in life expectancy.

145. For all the above reasons we find that removal of the Appellant to Morocco would breach the UK's obligations under Article 3 of the 1950 Convention on Human Rights. There is no need for us consider Article 8 and to engage with application of GS post Paposhvili.

146. The appeal is dismissed on protection grounds.

147. The appeal is allowed on Article 3 grounds.

Signed Joanna McWilliam Date 19 August 2021

Upper Tribunal Judge McWilliam

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[1] All asylum appeals are anonymised in the First-tier Tribunal in accordance with Presidential Guidance Note No 2 of 2011. UTIAC will follow the same general practice properly applying Upper Tribunal (IAC) Note No 1 of 2013: Anonymity Orders.

[2] R (on the application of Cart) v the Upper Tribunal [2011] UKSC 28 ; [2011] Imm AR 704 .

[3] Overriding objective and parties' obligation to co-operate with the Upper Tribunal

2.—

(1) The overriding objective of these Rules is to enable the Upper Tribunal to deal with cases fairly and justly.

(2) Dealing with a case fairly and justly includes—

(a) dealing with the case in ways which are proportionate to the importance of the case, the complexity of the issues, the anticipated costs and the resources of the parties;

(b) avoiding unnecessary formality and seeking flexibility in the proceedings;

(c) ensuring, so far as practicable, that the parties are able to participate fully in the proceedings;

(d) using any special expertise of the Upper Tribunal effectively; and

(e) avoiding delay, so far as compatible with proper consideration of the issues.

(3) The Upper Tribunal must seek to give effect to the overriding objective when it—

(a) exercises any power under these Rules; or

(b) interprets any rule or practice direction.

(4) Parties must—

(a) help the Upper Tribunal to further the overriding objective; and

(b) co-operate with the Upper Tribunal generally.