IN THE UPPER TRIBUNAL
IMMIGRATION AND ASYLUM CHAMBER

Case No: UI-2021-001445

First-tier Tribunal No: PA/01335/2020

THE IMMIGRATION ACTS

Decision & Reasons Issued:
On 23 October 2023

Before

UPPER TRIBUNAL JUDGE HANSON

Between

MAA
(ANONYMITY ORDER MADE)

Appellant

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Mr Karnik instated by Fisher Stone Solicitors.
For the Respondent: Ms Z Young, a Senior Home Office Presenting Officer.

Heard at Phoenix House (Bradford) on 3 July 2023

Order Regarding Anonymity

Pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008, [the appellant] (*and/or any member of his family, expert, witness or other person the Tribunal considers should not be identified*) is granted anonymity.

No-one shall publish or reveal any information, including the name or address of the appellant, likely to lead members of the public to identify the appellant (*and/or other person*). Failure to comply with this order could amount to a contempt of court.

DECISION AND REASONS

1. Following a hearing at Bradford on 27 February 2023 it was found a judge of the First-tier Tribunal had materially erred in law in the decision to dismiss the appeal. That decision was set aside albeit it is noted there are a number of unchallenged findings made by the Judge recorded at [9] of the Upper Tribunal determination in the following terms:

> 9. There are a number of unchallenged findings including the appellant's nationality, date of birth, immigration history, based upon the report of Dr Kovvuri that the appellant is a vulnerable witness, the previous determination of Judge Bradshaw forming the starting point of this appeal as per the Devaseelan principles, that the findings of Dr Waheed and Dr Kovvuri in relation to the appellant's mental health issues are not challenged, there was no challenge before the Judge to the report of Alison Pargeter, the appellant has some family members in Egypt, the appellant did not before the Judge seek to rely on Article 8 ECHR in relation to his family life.

2. The scope of this hearing as defined by the Upper Tribunal is to further consider any risk to the appellant based upon the country information and his Article 3 ECHR medical claim.
3. The appellant has provided further evidence by way of an updated medical report from Alison Summers dated 11 May 2023, a country expert report written by Alison Pargeter dated 29th July 2020, an addendum country expert report by the same author dated 15 June 2023, and an updated appellant's witness statement dated 27 June 2023. The Secretary of State relies upon the Country Policy and Information Note, Egypt: Opposition to the state, version 3.0, dated November 2022. All the evidence made available for the purposes of these proceedings has been considered and factored into the decision-making process even if not specifically referred to.
4. At the outset of the appeal I indicated to the advocates that it is my view that this appeal should be allowed. Miss Young was given time to make a telephone call to liaise with a senior colleague and following her return to the court room made no further submissions. I now give my reasons for that indication.

Discussion and analysis

5. The appellant is a citizen of Egypt born on 10 December 1999. He retains contact with his mother and sister in Egypt on the telephone, speaking to them once or twice a month via a friend who acts as a conduit for the calls. The appellant states he is unable to contact his mother directly as he is worried that her telephone line might be monitored by the authorities in Egypt, and he did not want his mother to be in any kind of trouble. The appellant states his father passed away in October 2021.
6. The appellant refers to medical treatment having to be paid for in Egypt and in relation to his own position he writes:

> 10. Since I have been in the UK my mental health has really deteriorated. If I returned, I will definitely not be able to find help or support in Egypt. I never had mental health problems when I was living in Egypt. I was not aware of any mental health care in Egypt and if it does exist, I would have no way of paying for it. When I was there, if anyone was thought to have mental health problems - they would be thought of as crazy and ill treated by the people they lived among.
>
> 11. I would also be frightened that if I went to a doctor or hospital in Egypt that there might be a link between the medical system and the authorities and that could put me at risk. I could not tell anyone about the trouble that I had in Egypt and the reasons that I now have the mental health problems that I have. This would also stop me from accessing the care I need, as any doctor or other staff at a medical facility could contact the authorities about me and would refuse to treat me because they would not want to get into trouble with the authorities.

7. The appellant states that he is frightened that if he returned to his own village he would be found by the authorities. At [13 – 14] of his witness statement the appellant writes:

> 13. My mental health has deteriorated a lot during my time in the UK and I feel hopeless and out-of-control of my own life and future. I have been very reliant on

the support that I have received from Mark and his team. Without their support and knowing that there was someone that cared for me, I am not sure that I would still be alive. Without that I would feel that this life is not worth living and that there is no place for me on this earth.

14. If I was told now that I had to go back to Egypt, I do not believe that I could have a life there, and it would be better to end my life than to return to Egypt.

The medical evidence

8. It is not disputed that the appellant has mental health needs and is a vulnerable witness.
9. The updated medical evidence of Dr Alison Summers contains a clinical summary in the following terms:

MAA reports mistreatment by Egyptian authorities including: witnessing abuse of his parents; imprisonment; being verbally abused; being beaten and kicked; and there are indications that he may have been sexually abused. He expresses fear that if returned to Egypt he will be further mistreated and killed.

He reports of physical symptoms including chronic spontaneous urticaria (a skin condition) and abdominal pain, both linked to stress, and also anxieties about his physical health. He smokes tobacco.

He told me about multiple psychological symptoms including: significant low mood; nightmares; intrusive memories; sleep disturbance; feeling in danger; distressing memories and efforts to avoid these; loss of motivation; difficulties with attention and concentration; preoccupation with his situation; difficulty controlling anger; difficulties relating to others; in addition to psychotic symptoms at the time when he is most depressed. He described how his difficulties have a significant effect on his functioning. At the assessment I observed external indications of many of his reported symptoms including of low mood, tension, and difficulties with attention and concentration.

I have made a diagnosis of PTSD and depression, and have noted the history of psychotic symptoms, as well as current somatic symptoms, and probably dissociation. I was not able to exclude acquired brain injury.

I have discussed my view that MAA's PTSD is primarily caused by mistreatment in Egypt. I have noted other factors I believe to be contributing to his psychological difficulties including: separation from his family; the death of his father; inability to progress in his life; uncertainty over his future; limited activities; social isolation.

In my view, taken together, the physical and psychological clinical findings are, in the terms of the Istanbul Protocol (2022) **highly consistent** with the treatment that MAA reports.

I have identified a very high risk of deterioration in MAA's mental health if he believes himself at a heightened risk of being returned to Egypt, and if he is returned to Egypt.

I have identified a low risk of suicide while MAA maintains hope of a positive decision on his asylum claim. However, I have explained my view that there would be a **high and immediate risk of suicide** if he loses this hope, or is returned to Egypt. I have also noted risks of self neglect and violence to property at times when his mental health is worse.

I have made recommendations for treatment, in particular that if MAA's mental health deteriorates, or his situation changes, it requires urgent reassessment of the suicide risk.

In my view clinical factors significantly affect MAA's ability to give his account, and also affect the impact on him being questioned. I have made recommendations for maximising his ability to give evidence.

The country expert evidence

10. The appellant's objective fear of risk on return arises from his experiences in Egypt including his arrest and detention by the authorities. Two reports have been provided by the country expert. In her earlier report dated 29 July 2020, Alison Pargeter writes:

    2.43 It is entirely plausible therefore that if H (the appellant's brother) was involved with the Brotherhood, MAA would have been arrested and taken from his home in the way he describes. This would have been a way for the regime to pressurise his brother and his family more widely and a way for the authorities to ascertain the nature of MAA's own connections to the Muslim Brotherhood movement. MAA's description of being questioned about his brother and the Muslim Brotherhood is in keeping with what one would expect in such circumstances.

    2.44. The fact that MAA was released without any conditions indicates that the authorities had no immediate interest in him. However, his desire to flee the country at this time is entirely understandable. His arrest would have marked him out in the eyes of the authorities, and if the security services were still concerned about his brother, they could well have tried to rearrest him in order to try to extract further information from him.

    2.45. If the Egyptian regime suspects MAA of having active links to the Muslim Brotherhood, he will be at real risk where he to be returned to Egypt. While it is true that the authorities have gone after high- and middle- ranking members of the movement, the fact that they have arrested and detained so many thousands of suspects is testimony to the fact that it isn't only senior figures that have been arrested and detained.

    2.46. In November 2018, the UK Upper Tribunal issued a decision in which the Judge concluded, "Whilst there is reference to only leaders and high – level members of the Muslim Brotherhood being targeted, there is also a great deal of evidence that any association with that organisation is enough to put a person at risk. It seems clear on the basis of the evidence I have that the Egyptian authorities are demonstrating a determination to completely destroy the Muslim Brotherhood and that they are meting out very severe punishments to anyone they come across who supports it. This is clearly designed, not only as a punishment to those but as a deterrent to others from continuing their support … The evidence does not show that it is only high profile members of the Muslim Brotherhood who are at risk, but anyone perceived to have links with or to be supportive of the organisation". This assessment aligns with my own view of the situation in Egypt.

    2.47. As such, if MAA were to be returned to Egypt and if the authorities continued to suspect him of active involvement with the movement, he could find himself interrogated and detained. As noted above, the Egyptian security services routinely use torture against suspects in detention, meaning that in such a scenario, there is a risk that MAA could be subjected to abuse and mistreatment.

    2.48. Were MAA to be suspected of having active links to the Muslim Brotherhood, the risk they would face would extend across the whole of the country. The regime has a zero tolerance attitude towards the Muslim Brotherhood and anyone suspected of being actively involved with the group will be at real risk where ever they were located.

11. In the addendum report, dated 15 June 2023 Alison Pargeter writes:

    1.16. It is evident therefore that the regime continues to display a zero tolerance approach to opposition activities of any kind. The Muslim Brotherhood is still outlawed and classified as a terrorist organisation, and anyone suspected of involvement with the group would be at risk of serious harm.

1.17. As such, I am still of the opinion that if the regime suspected MAA of having active links to the Muslim Brotherhood, or if they wanted to find out more information about his brother's involvement with the movement, he would be at real risk of harm at the hands of the Egyptian state upon return.

12. The appellant has been in the UK for a number of years now. There is no evidence he has a valid Egyptian passport and will therefore be returned on an Emergency Travel Document issued by the Egyptian Consulate in the UK. The authorities will be aware he is being returned. There have been a number of terrorist attacks in Egypt, outside the North Sinai region, and checks will therefore be made upon the appellant at the point of return. The appellant was clearly of interest to the authorities previously and was questioned in relation to a family member's involvement with the Muslim Brotherhood. It cannot be excluded that the appellant may be questioned about why he fled Egypt, about his own political beliefs and affiliations, especially in light of the country information, and those of his family members. It cannot be ruled out, even if the conclusion of such enquiries is that the appellant does not have an adverse political view through support of the Muslim Brotherhood, that the appellant will not experience ill-treatment sufficient to breach Article 3 ECHR on the basis of the expert report.
13. Of more concern, however, is the impact upon the appellant's mental health. He states that arrangements are still made to enable him to contact his mother through a third party as he worries that the authorities will monitor his mother's telephone line which may place her at risk. He therefore has a subjective fear of the authorities. The expert report indicates that, if he remains suspected of association with the Muslim Brotherhood, that fear of the authorities is objectively well-founded.
14. The medical evidence clearly shows that there is a high risk of suicide if the appellant believes he is going to be returned or steps are taken to return him to Egypt. In relation to the question of whether the appellant is entitled to succeed pursuant to Article 3 ECHR on the basis of his medical needs, it is necessary to consider the test set out in AM (Zimbabwe) [2020] UKSC 17, which conformed that the applicable test is that set out in Paposhvili v Belgium (Application No.41738/10) that there is a real risk on account of the absence of appropriate treatment in the receiving country or the lack of access, of being exposed to a serious, rapid and irreversible decline in his or her state of health or to a significant reduction in life expectancy.
15. In relation to suicide there is a high threshold as set out by the Court of Appeal in J v Secretary of State the Home Department [2005] EWCA Civ 629. In his judgement Dyson LJ stated that the cases being considered by the Court meant it was possible to amplify the test to the following extent:

26. First, the test requires an assessment to be made of the severity of the treatment which it is said that the applicant would 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].

27. 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:

> "In so far 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 para [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…"

28. Thirdly, in the context of a foreign case, the article 3 threshold is particularly high simply because it is a foreign case. And it is even higher where the alleged 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*.

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

30. 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.

31. 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 an applicant's claim that removal will violate his or her article 3 rights.

16. In relation to the first question there is a real risk, for the reason identified above and in the expert reports, that the appellant will be exposed to ill-treatment attaining the minimum level of severity and that his fears in this respect are well-founded.
17. The causal link between the act of removal to Egypt and the inhumane treatment relied upon is made out in the expert report if the appellant comes into contact with the authorities who wish to undertake further enquiries or investigations in relation to his views or those of any family member.
18. The fear is objectively well-founded.
19. The question in this case relates to the sixth of the J questions, whether the receiving state has an effective mechanism to reduce the risk of suicide.
20. That ties in with the need for it to be established that there is adequate psychiatric care on return to assist the appellant to which he will have proper access.
21. In relation to psychiatric services in Egypt, Alison Pageter writes in her addendum report of 15 June 2023:

    3.1 MAA has been diagnosed with PTSD and depression, and in her report dated 11 May 2023, Dr Alison Summers has identified a very high risk of deterioration in MAA’s mental health if he is returned to Egypt. Dr Summers has also identified that there would be a ‘high and immediate risk of suicide’ if he is returned to Egypt. She has recommended that MAA undergo further specialist psychological therapy.

    3.2. As detailed in my original report, Egypt’s mental health care system is in crisis, and suffers from an array of problems that affect the provision of care. The situation has not changed since I submitted my original report. The sector remains hampered by a shortage of qualified personnel. According to the World Health Organisation’s (WHO) most recent Mental Health Atlas (2020), Egypt has just 0.84 psychiatrists, 0.86 psychologists and 3.90 nurses per 100,000 of the population. The number of psychiatrists and mental health nurses has actually decreased since the previous WHO mental health Atlas was published in 2017. By contrast, the UK has 13.76 psychiatrists, 19.77 psychologists; and 55.62 mental health nurses per 100,000 of the population. Germany has 14.22 psychiatrists and 55.08 psychologists per 100,000 of the population.

3.3 Studies published in the time since I submitted my original report have also flagged up the problem of inadequate numbers of mental healthcare professionals. A study published in the Journal of Psychiatric Mental Health Nursing in 2021 for example cited the dearth of psychiatrists as a 'barrier to recovery,' with one Egyptian psychiatrist commentating, "there is a big shortage of psychiatrists in Egypt and that makes medical care deficient." A study published in the BMC Psychiatry Journal in March 2023 of serve that one of the challenges to accessing mental health care in Egypt was "a shortage of healthcare providers."

3.4 There is also still a shortage of mental healthcare facilities. That was published by the Consortium Psychiatricum in 2022 observed, "Mental hospitals are often based in urban areas. The numbers are insufficient in areas such as Sinai, Matrouh, Hurghada, and New Waadi. Therefore, those who live in rural areas and seek to gain access to mental care burdened by travel and lodging expenses, in addition to time and travel effort. Similarly, forensic psychiatric services are centralised (at Khanka, Abbassiya , and Ma'amoura). The patients, especially those from rural areas, often go to traditional healers before or after seeking medical advice from the health system. Outpatient services are hospital-based so the same issues (travel, expenses, effort and use of traditional healers) also apply to these services."

3.5. In February 2023, the Egyptian Street news site cited the case of a young student who had sought help for her mental health problems, going to the Al-Demerdash public hospital in Cairo. She arrived early in the morning to find it already overcrowded, describing, "people had been waiting since 5 or 6 AM. There were children, teenagers, people from other governorates and from the countryside. […] The lady responsible for registration started handing out tickets, and people started hitting and stepping over each other. It was very, very disturbing to watch.… I was caught between two men fighting to get to the [registration] window, and I started crying. The lady saw me crying, handed me a ticket, and told me to get out of the line." She went on to explain how she waited for a further two and a half hours for her appointment, which lasted thirty minutes, and which was repeatedly interrupted by the comings and goings of nurses through the office. She describes, "There was no privacy in the appointment. I was crying my heart out… The doctor had a kind of poker face, he wasn't really sympathetic. He asked questions from a sheet, and checked my answers 'yes' or 'no' or wrote them down. Then he prescribed me some medicine […].

3.6. Issues of overcrowding are still problematic. Some of this overcrowding is as a result of bed blocking, with families often refusing to accept their relatives back home after they have spent time in a mental health institution. In February 2021, the National news site reported how, "sixty percent of the beds are occupied by long-stay patients, according to the WHO, and the country's public mental health hospitals are overwhelmed as a result." The report cited Dr Nasser Loza, the head of the private Behman Hospital in Cairo who explained, "we have a large number of beds in Egypt, but that all blocked because the community will not take its patients back."

3.7. In 2021, Dr Loza commented, "if someone suffers from a psychiatric disorder and they go to hospital, the expectation is that they get treated and come out again… But there seems to be a growing culture that people wouldn't mind keeping their son or daughter in hospital for ever… And that's quite a task in a country of 100 million." Thus, the facilities that do exist are overwhelmed, making it even more difficult for patients to access treatment.

3.8. In addition, the professionalism and expertise of some therapists who are practising in Egypt is highly questionable. As Yasmin Magdy, a Clinical Psychologist, Marriage Therapist and Addiction Counsellor based in Cairo explained in July 2020, "because we don't have an official board of psychology in Egypt, this has left a lot of room for unethical therapists… We have had a terrible reputation over the years. No one really understood what we do, and many

therapists in Egypt, who do not have the proper education, are treating patients in a very wrong way. People come to therapy not knowing what they are here for."

3.9 Patients are also sometimes given treatment without their consent or full knowledge. One of the criticisms of amendments that were made to the 2009 mental health law in December 2020, which included that the patients written consent must be acquired before they be given electroconvulsive therapy (ECT) (or in the event that the patient loses capacity, the that the consent of his or her family must be given), was that the legislation allow doctors to give ECT without a second opinion for up to 3 sessions. In November 2021, Dr Michael Elnemais Fawzy, a consultant psychiatrist explained how in voluntary or voluntary admission to a psychiatric institution needed to be separated out from consenting to treatment, noting, "consent should be gained with the provision of accurate information and without manipulation, for example, practitioners should not tell the person that there will be given a 'sleep therapy' when they are in fact given ECT." Indeed, these amendments were introduced in order to try to prevent the misuse that was occurring in some hospitals regarding the use of ECT.

…

3.13. Were he to return to Egypt, therefore, I am still of the opinion that MAA would struggle to obtain adequate treatment and care for his mental health problems. Demand continues to far outstrip supply, meaning that there is a real risk, he will not be able to access treatment in the public sector. Furthermore, the main focus is still on in patient care and medication rather than on individually tailored therapy, such as that recommended by Dr Summers. As the National reported in 2021, "Shortages in space, funding and staff in the country's public psychiatric hospitals and the lack of a community-based approach to treating patients exasperates Egypt's inability to provide the mental health services necessary." Indeed, MAA could well find it very difficult to access the treatment Dr Summers is recommended.

3.14. There is also still a lack of community-based care and rehabilitation. In 2022, the Consortium Psychiatricum published an article on community mental health services in Egypt which stated, "another problem is that there is still a lack of systems for outreach to people with severe mental illness living at home, for home-based rehabilitation, and for immediate services at governorate or district level. There are no community rehabilitation centres, daycare centres, or halfway houses across the country, apart from those linked to the national hospitals of Abassiya, Heliopolis, and Khanka. When patients are discharged from hospital, there is a problem with them being unable to continue to access medicines."

3.15. As noted in my original report, MAA could try to access treatment privately, where there is a greater availability of different therapies. However, this is still extremely costly and the system lacks proper regulation. In 2021, the Journal of Psychiatric and Mental Health Nursing cited an Egyptian psychologist who warned that service users may get abused by 'intruders', who illegally sell themselves as mental health care providers, describing, "the field itself has some intruders, like life coaches and nonspecialists who sell themselves as MHP's. They do be calm, especially with the lack of mental health awareness in Egypt."

…

3.17. As the crisis care, this is also underdeveloped, in part because of the ongoing stigma surrounding suicide. An article in the Lancet in 2021 noted, "in Egypt, suicide is stigmatised and considered to be morally reprehensible, and thus thought to be substantially underreported." Although there are now some suicide hotlines, in some cases, these numbers do not work. This includes the Ministry of Health's own mental health and addiction hotline, which is sometimes temporarily unavailable. However, there is a Ministry of health number through which cord is directed to their nearest mental health facility, although as the Egyptian Streets website reported in 2019, "despite the availability of some mental health

assistance, it doesn't seem that there is an immediate hotline a person can call immediately for assistance."

...

3.18. In March 2023, the Health Minister announced that he had commissioned a study to look at establishing psychiatric services in emergency departments of general hospitals. However, these have yet to be established, meaning that anyone at risk of suicide has no guarantee that they can get through to someone to get immediate help.

3.19. I remain of the opinion therefore that were he to return to Egypt, there will be a real risk that MAA would not be able to access adequate treatment for his mental health problems.

3.20. However, were he to be hospitalised on account of his mental health problems, who will be at risk of ending up in an overcrowded and ill-equipped institution, with substandard conditions of poorly trained staff. He may also be subjected to neglect and abuse.

22. An additional element in this appeal is that of the nature identified by the Court of Appeal in Y and Z (Sri Lanka) v Secretary a State the Home Department [2009] EWCA Civ 362.
23. The appellant has an objectively well-founded fear of ill-treatment on return to Egypt. His fear is of the Egyptian authorities. He fears that if he seeks treatment the authorities will become aware and arrest him and subject him to further ill-treatment. He is therefore not likely to seek treatment as a result of believing that if it does his life will be in danger and that it is better to kill himself than to suffer further ill-treatment.
24. The Secretary of State has not sought to commission their own psychiatric expert to have the appellant examined or to provide rebuttal evidence. I find it credible based upon the expert reports that the appellant will take his own life as a means of escaping from what he fears and that even if treatment was available in Egypt he will not access the same as he is not capable of doing so. This will result in his suffering a serious, rapid and irreversible decline in his state of mental health leading to a significant reduction in life expectancy as a result of an act of suicide directly linked to his return to Egypt and lack of access to appropriate treatment.
25. I find returning the appellant to Egypt of the facts so this case will lead to a breach of article 3 ECHR on the basis of his medical needs.

Notice of Decision.

26. For the above reasons the appeal is allowed on Refugee Convention grounds and pursuant to Article 3 ECHR.
27. I have been able, since the promulgation of the original version of this decision, to listen to the audio recording of the hearing at the Bradford Hearing Centre in which I clearly indicated to the parties that I allow the appeal on Refugee Convention grounds on the basis of the real risk he faced as a result of an actual or implied adverse political opinion arising from the connection with the Muslim Brotherhood and the factual matrix. The appellant's representatives have referred to the fact this point has not been amply clarified resulting a grant of leave to the appellant only pursuant to Article 3 ECHR on the basis of medical needs. I have amended the decision to clarify basis on which the appeal was allowed in the hope it will end any ambiguity arising.

C J Hanson

Judge of the Upper Tribunal
Immigration and Asylum Chamber

23 August 2023
Amended 23 October 2023