SP(Risk-Suicide-PTSD-IFA-Medical Facilities) Kosovo CG [2003] UKIAT 00017

IMMIGRATION APPEAL TRIBUNAL

Date heard: 4 February 2003
Date notified.: 01/07/2003

Before:-

DR H H STOREY (CHAIRMAN)
RT HON THE COUNTESS OF MAR
MR A A LLOYD JP

Between

Appellant

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

DETERMINATION AND REASONS

1. The appellant, a national of Federal Republic of Yugoslavia (FRY), has appealed with leave of the Tribunal against a determination of Adjudicator, Miss M Lingard, dismissing the appeal against the decision of the Secretary of State refusing asylum although granting limited leave until 18 November 2002. This was a s. 69(3) appeal. Ms J Alexander of Counsel instructed by Messrs Thompson Leatherdale Solicitors appeared for the appellant. Miss M Banwait appeared for the respondent.

2. This appeal requires us to address issues relating to the assessment by adjudicators of medical evidence and the proper approach to be taken in human rights cases based on a claim that return would give rise to a real risk of suicide.

3. The Tribunal has decided to dismiss this appeal.

4. The appellant based his claim on submissions that if he were now to return to Kosovo, he would be at high risk of taking his own life in order to avoid reliving

traumatic experiences. At 14 years old he had escaped from his family home when Serb militiamen had set it on fire. He had subsequently learnt that his parents had been killed then or later. He had been told they were buried in a mass grave. Before he left Kosovo he had had to survive begging on the streets doing his best to avoid being harmed or used by criminal gangs.

5. His asylum grounds of appeal were conceded before the adjudicator but it was maintained that in view of his traumatised condition the decision refusing him asylum would amount to a breach of Arts 3 and 8 of the ECHR. The adjudicator did not accept there would be any breach of the claimant`s human rights. Leave was granted confined to the Arts 3 and 8 issues.

6. In our view leave should not have been granted since at that time (3 September 2002) the appellant still had limited leave to remain which was not due to expire until 18 November 2002. Whilst by virtue of the Court of Appeal judgment in *Saad, Diriye and Osorio* (2002) INLR 34 the claimant was entitled to have his *asylum* grounds of appeal determined on the hypothetical basis of whether he would face a real risk of persecution as at the date of hearing, the same considerations cannot apply in an appeal based on *human rights grounds*. In an asylum-related appeal based on human rights grounds there is no link to a status recognised at international law or indeed to any status established by UK domestic law. Furthermore, whilst Strasbourg has identified the proper test as being, like that under the Refugee Convention, one of current risk to be assessed as at the date of hearing, the obverse side of this recognition is that the risk has to be shown to be an imminent one. A risk cannot be imminent if the appellant has available a further effective remedy: see *Vijayanathan and Pushparajah v France* (1992) 15 EHRR 62. In the instant case, since it remained open to the appellant as at the date of hearing before the adjudicator to have applied for an extension of limited leave to remain and to have appealed if refused, there was just such an effective remedy available.

7. However, leave was granted and we are required to decide the appeal on the basis of the situation at the date of hearing. That is critical in this case because by the time of the hearing before us (4 February 2003) the appellant no longer had limited leave to remain and so was at imminent risk of removal. We were informed that the appellant had not been granted any extension of his exceptional leave to remain. It would appear that ELR was granted because the appellant was a minor and was not renewed once he reached 18 on 18 November 2002.

8. The adjudicator accepted the claimant had given an entirely credible account in relation to his claimed experiences and that the appellant genuinely believed his parents were dead and that he had no close family members to return to.

9. However, the adjudicator was not persuaded that the appellant`s return would place him at real risk of treatment contrary to Art 3 or Art 8. She accepted that at 17 he was still a minor who had Post Traumatic Stress Syndrome (PTSD) and

unresolved bereavement with guilt about survival and self-blame. But she did not accept he would be at high risk of taking his own life if returned. She gave several reasons. Firstly she considered that in the principal medical report relied on, that by Consultant Psychiatrist Annette Goulden, no basis for this assessment had been given and in the guide attached to the addendum from Dr Goulden no mention was made of the general likelihood of the suicide option. Secondly she noted that there was no evidence of a history of self-mutilation. Thirdly she considered that the appellant's journey to the UK demonstrated a "certain independence of spirit" and that in the UK he was considered in a Social Services report to be physically well. She concluded that he had shown he could cope by undertaking studies and trainee employment as a chef and displaying a generally respectful attitude towards others and for the law. She noted that unilaterally he had requested a move from a YMCA establishment to his own accommodation within a house where facilities were shared and he appeared to be independent both financially and socially, albeit with important social services back up. Fourthly she noted the objective evidence indicating that there existed secondary schools in the appellant`s home area and that there were a number of specialist departments including in psychiatry and paediatrics at the main University hospital in Pristina together with 6 health centres operating within the municipality and one specialist psychiatric institution with 6 state-owned pharmacies and 23 private pharmacies operating in the Pristina municipality.

10. The principal contentions raised in the grounds and before us were that the adjudicator had wrongly rejected the medical evaluation that the appellant was a high suicide risk and had wrongly concluded that the objective country materials showed that persons in a vulnerable state requiring medical care for mental health problems would receive adequate care there. They stated that the adjudicator had erred in taking into account irrelevant factors such as the appellant`s character and progress in the UK and had effectively sought to give a medical opinion different from that of the medical expert.

11. We would accept that the first two of the adjudicator`s reasons cannot withstand closer examination.

12. It is now clear from Dr Goulden`s additional reports that there was a medical basis for her assessment. She referred in particular to recognised criteria for assessing depressive disorders: the Composite International Diagnostic Interview system as set out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV diagnoses) and the ICD10 which we understand to be a fully standardised and modified version of the Composite International Diagnostic Interview. She also referred to three other research studies. One said that regarding specific diagnoses, multivariate co morbidity analyses indicated the highest risk for suicide attempt in those suffering from anxiety disorder, particularly PTSD. Another dated 2001 stated that an emerging literature suggests that PTSD patients are at an increased risk for suicide and that "in assessing suicide risk among persons with PTSD, careful attention should be paid to levels of impulsivity, which may increase suicide risk, and to social

support, which may reduce the risk". Another study, a 1996 study by Ferrada-Noli designed to assess the prevalence of suicidal behaviour among asylum applicants diagnosed as having PTSD and the impact of cultural bias factors (such as religion and nationality), stated that:

> "Another noteworthy finding in the present study was that suicidal behaviour did not differ significantly between asylum applicants and refugees granted residence permits. Thus the notion that asylum applicants might manifest a higher frequency of suicidal behaviour, possibly due to the threat of imminent expulsion from the country, derived no support from our findings".

13. Albeit the medical evidence is not entirely consistent, it does appear that the adjudicator was wrong to say there was no history of attempted self-harm. There was, albeit as we shall see it was limited. We have disregarded the failure of Dr Goulden and other reports to mention this consistently because we believe it can be put down to the medical and social services persons involved having to produce reports in some haste within the constraints of their difficult work responsibilities.

14. However, in our view these two flaws do not seriously undermine the adjudicator's conclusion that return of the appellant would not in fact breach Art 3 or Art 8. Why we take that view will become clearer when we deal with the other grounds of appeal.

Evaluation of the medical evidence

15. The grounds of appeal take issue with the adjudicator's treatment of the medical evidence, arguing that, having accepted much of it, she should have been slow to reject that part of it indicating a breach of fundamental human rights. In order to address these grounds in more detail, we consider it is useful to summarise the main principles underlying the approach of the appellate authorities to cases involving evaluation of medical evidence.

The approach of the appellate authorities

16. The grounds in this case are not unique in complaining that the adjudicator failed to attach proper weight to (significant parts of) the medical evidence. The appellate authorities are frequently called upon to evaluate medical reports which deal with the risk facing asylum-seekers if returned in the light of their medical history. How should they go about this task? Drawing on past cases such as *Ademaj* [2002] 00979 and *Cinar* [2002] UKIAT 06624 and in particular on the starred determination of the Tribunal in *AE and FE* [2002] UKIAT 05237, it is possible to identify the following principles:

a) It is not the job of an adjudicator to make clinical judgments. That is the job of medical experts. Equally, however, it is not the function of medical experts to evaluate conditions in an appellant`s country of origin. Except in very rare cases they have no expertise about such matters.

b) Albeit not medical experts, adjudicators are perfectly entitled, when evaluating a medical report, to consider to what extent it is based on established medical methodology and criteria. Adjudicators should obviously be cautious about criticising medical reports unnecessarily, particularly given that they do not have the benefit of a medical report from the respondent so as to enable a comparison to be made. But by virtue of the frequency with which the immigration appellate authorities have to examine and assess medical reports in asylum-related cases, a fund of experience and knowledge has been built up, making it possible to identify what is expected from a "good report", and to discern which medical experts, among the many whose reports they see, produce reports based squarely on established medical methodologies and criteria. If confronted, therefore, with a diagnosis (or prognosis), which departs for no good reason from methodology and criteria established within the medical profession, they cannot be expected to overlook that kind of deficiency. And to the extent that a medical report fails to base itself on established medical methodologies and criteria, an adjudicator may be justified in attaching lesser weight to it as a consequence. A medical report purporting to give an in-depth diagnosis of PTSD based on one superficial interview is an obvious example. As the Tribunal highlighted in *AE and FE*, an adjudicator is also entitled to assess to what extent a medical report is based on examination which has been conducted as soon as possible after the time of the injury or event which is said to have caused the physical or psychological disorder.

c) Irrespective of the quality of the medical report, the assessment of risk upon return that has to be made by an adjudicator must be based on the notion of real risk as established by refugee law and human rights law. That will not necessarily be the same concept of real risk applied by medical experts.

d) Since an adjudicator must base his assessment on a consideration of all the evidence viewed in the round, it is always ultimately a matter for an adjudicator what weight if any to attach to medical evidence. In order to assess whether there is a real risk, the medical evidence has to be placed *alongside* all the other evidence. Where a doctor's report has based some of its key findings on the truth of what his patient has told him about past experiences and/or current fears, it may well be that an adjudicator who having made a global assessment finds the appellant`s account not credible, will reject that report`s principal findings. Depending on the particular circumstances, medical evidence stating that a person`s injuries or condition is "consistent with" his account of what happened to him in his country of origin may or may not add credence to his claim.

The treatment of self-harm by Strasbourg jurisprudence

17. This case involves a claim based on a high risk of suicide being a foreseeable consequence of removal. How should the appellate authorities approach such a claim? Insofar as the issues arising under the Refugee Convention and the Human Rights Convention are concerned, suicide is self-evidently a type of serious harm: *Pretty v UK* (2002) 35 EHRR 1. Although

suicide is a form of self-harm and is to be distinguished from harm inflicted by others, if the real risk of it is a foreseeable consequence of a removal decision, then that may well be enough to establish serious harm under both Conventions. Under the Human Rights Convention we would accept in principle that if the evidence in a case establishes that a removal decision will expose a person to a real risk upon return of committing suicide, then a decision requiring him to return could give rise to a violation of Article 3 and Article 8. So much we understand to be established by cases such as *D v UK* (1997) 24 EHRR 423 and *Bensaid v UK* [2001] INLR 325. In *Bensaid* at paragraphs 36 and 37 it was accepted that in principle deterioration in mental condition causing the risk of self-harm resulting from difficulties in obtaining medication, could fall within the scope of Art 3.

18. We recognise too following *Bensaid*, that, even if it was not reasonably likely a person would commit suicide upon return, there could still be a breach of Art 3 or Art 8 if a claimant could show, because of other mental or psychological problems, that the decision to return him would expose him to a real risk of serious harm or significant detriment. Following the Court of Appeal judgment in *Ullah and Do* [2003] INLR 74, however, it would appear there is little or no ambit for an Art 8 claim when real risk of significant detriment in the receiving state is the sole ground on which it is advanced.

The current medical approach to suicide cases

19. With these key principles in mind, we need next to set out some relevant background on the current medical approach to suicide cases and then turn to consider the medical evidence specific to this case.

20. In relation to assessment by doctors of risk of suicide, one common point of reference is the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, Fourth Edition (DSM-IV), Text Revision, Washington DC, American Psychiatric Association 2000. As we shall see, the Consultant Psychiatrist who did the main reports in this case refers to this text. This Manual states that one of the nine symptoms forming diagnostic criteria for a major depressive episode is:

> “Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide”.

21. This aspect is elaborated further:

> “Frequently there may be thoughts of death, suicidal ideation, or suicide attempts (Criterion A9). These thoughts range from a belief that others would be better off if the person were dead, to transient but recurrent thoughts of committing suicide, to actual specific plans of how to commit suicide. The frequency, intensity, and lethality of these thoughts can be quite variable. Less severely suicidal individuals may report transient (1-2 minute), recurrent (once or twice a week) thoughts. More severely suicidal

individuals may have acquired materials (e.g. a rope or a gun) to be used in the suicide attempt and may have established a location and time when they will be isolated from others so that they can accomplish the suicide. Although these behaviours are associated statistically with suicide attempts and may be helpful in identifying a high-risk group, many studies have shown that it is not possible to predict accurately whether or when a particular individual with depression will attempt suicide. Motivation for suicide may include a desire to give up in the face of perceived insurmountable obstacles or an intense wish to end an excruciatingly painful emotional state that is perceived by the person to be without end.

> A diagnosis of a Major depressive Episode is not made if the symptoms meet criteria for a Mixed Episode (Criterion B). A Mixed Episode is characterised by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period. The degree of impairment associated with a Major Depressive Episode varies, but even in mild cases, there must be either clinically significant distress or some interference in social, occupational or other important areas of functioning (Criterion C). If impairment is severe, the person may lose the ability to function socially or occupationally. In extreme cases the person may be unable to perform minimal self-care (e.g. feeding or clothing self) or to maintain minimal personal hygiene".

22. In outlining associated descriptive features and mental disorders this text goes on to state:

> "Individuals with a Major Depressive Episode frequently present with tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain (e.g. headaches or joint, abdominal, or other pains). During a Major Depressive Episode, some individuals have Panic Attacks that occur in a pattern that meets criteria for Panic Disorder. In children, separation anxiety may occur. Some individuals note difficulty in intimate relationships, less satisfying social interactions, or difficulties in sexual functioning (e.g. anorgasmia in women or erectile dysfunction in men). There may be marital problems (e.g. divorce), occupational problems (e.g. loss of job), academic problems (e.g. truancy, school failure). Alcohol or Other Substance Abuse, or increased utilisation of medical services. The most serious consequence of a Major Depressive Episode is attempted or completed suicide. Suicide risk is especially high for individuals with psychotic features, a history of previous suicide attempts, a family history of completed suicides, or concurrent substance use. There may also be an increased rate of premature death from general medical conditions. Major Depressive Episodes often follow psychosocial stressor e.g. the death of a loved one, marital separation, divorce). Childbirth may precipitate a Major Depressive Episode, in which case the specifier with Postpartum Onset in noted."

The medical evidence in this case

23. The medical evidence in this case consisted in the following.

- Report of 11 October 2001 from Mr Andrew Robinson, Care Manager, West Berkshire Social Services Adolescent Team. Mr Robinson notes that aside from the psychological issues relating to PTSD Mr Plaku had not presented any health issues and has made good progress in studies and in vocational work and had friends in Oxford and in Reading. He had adequate self care skills and was said to be "… a mature young man who has survived great adversity".

- Psychiatric Report by Annette Goulden, Consultant Child and Adolescent Psychiatrist dated 7 January 2002. In her "Summary" she stated that the appellant demonstrated all the diagnostic criteria for PTSD. His sleep was helped by medication but he had told her it made it difficult for him to wake up in the mornings in order to attend college so he stopped taking the tablets. He had an unresolved bereavement due to the death of his other family members, particularly his parents. This compounded the emotional trauma consequent upon the PTSD. She concluded as follows:

> "If Mr Plaku returns to the situation where these traumatic events took place, he will without doubt re-experience the trauma emotionally, physically and psychologically. Undoubtedly, Mr Plaku has been supported since his arrival in the UK and has made excellent use of any opportunity offered to him, e.g. to learn English and start training as a chef. However, independently of any other motives he may have to remain in this country, I am confident that he has Post Traumatic Stress Syndrome and unresolved bereavement, with guilt about survival and self-blame.
>
> My belief is that if Mr Plaku returns to his own country there is a high risk that he will take his own life in order to avoid re-experiencing the traumatic events of his childhood".

24. She also described a lack of interest in activities with his peer group and hyper-vigilance and lack of trust in people he does not know. She said he avoided going out on his own.

- Addendum Psychiatric Report by Annette Goulden on appellant dated 31 January 2002. In this report Dr Goulden set out her diagnostic criteria for PTSD and went on to summarise what the appellant had told her in the course of two interviews in November and December of 2001. We have already noted the sources and studies she said she relied on. At paragraph 16 with reference to the November interview she wrote:

> "His mood was consistently serious and low and his facial expression masked. He told me he had suicidal thoughts but had no real intention of taking his own life at this time. "

25. At paragraph 24 she said the appellant did not describe intense psychological distress, such as the terror experienced with his bad dreams or a state of panic. However, he avoided situations, as far as possible, which would resemble aspects of the traumatic event (e.g. fireworks). At paragraph 26 she said his main concern was "to avoid returning to the source of the traumatic memories, that is, returning to Kosovo". At paragraph 40 she said that from what the appellant had told her and from her observations of him, she believed there was evidence that the disturbance was causing significant distress as well as impairment in social functioning. At paragraph 42 she wrote:

> "Mr Plaku`s description of events and of his current mental state accords with the DSM IV criteria for PTSD. Both Criteria for Section A are fulfilled. At least three of the criteria from Section B are met. Most of the criteria from Section C are described and at least three of those in Section D. E and F criteria are also present. Duration is chronic (more than three months) and not likely to be of delayed onset".

- Addendum Psychiatric Report by Annette Goulden on appellant of 25 March 2002. In 5c of this report, Dr Goulden said that in the course of his two interviews which took place before her original report, the appellant had described two clear and serious suicidal attempts while in Kosovo. In 5d she said the appellant had described persistent low mood with bleak and pessimistic views of the future and persistent suicidal thoughts when he is alone. She said he had told her he would kill himself if he returned to Kosovo "and, in view of the general truthfulness of his account, I have no reason to disbelieve this".

26. She went on to explain that the appellant had been referred for treatment at a specialised Trauma Clinic in Oxford.

27. At 6a she mentioned research evidence showing a proven connection between adolescent suicidal behaviour and stress. She cited the 1996 study we have already mentioned. At 6b she noted that:

> "It is well-recognised that re-exposure to the scene of the traumatic event causes the person to be re-traumatised. It is for this reason that people with PTSD make huge efforts to avoid revisiting the scene of the trauma, whether it is in the physical state or the memory state…. Facing the traumatic past without the support of a stable home environment, social network and therapeutic setting may be intolerable and precipitate severe avoidance reactions such as suicide….".

28. In her Conclusions at 7 she wrote:

> “I believe Mr Plaku is at serious risk of committing suicide if he returns to Kosovo. This is based on my assessment of his current mental state of chronic depression, together with a diagnosis of PTSD within the context of lack of family support in Kosovo and the low likelihood of the intensity of treatment he requires. …Thus, a return to his country will re-expose him not only to the memories of being burnt, but also to longer term traumatic events of his adolescence. Re-stimulation of these memories, together with the impact of bereavement from his family, could lead to unbearable recurrence of trauma. This would be within the context of the further loss of his educational and social attainments in this (sic) UK so far and major adjustment required for any person returning to Kosovo.

- Letter of 22 October 2002 from Dr Michael Hobbs, Consultant Psychotherapist, Psychotherapy Department, Oxfordshire Mental Healthcare NHS Trust. He said he had not seen reports from Dr Goulden “but Mr Plaku`s suicide risk was identified by Suzanne Rose (Clinical Nurse Specialist in Psychological Trauma with the Berkshire Psychological Injuries Unit) who referred Mr Plaku to me earlier this year. When I interviewed Mr Plaku first on 14 March 2002, he acknowledged that he had considered suicide at times since escaping from Kosovo in autumn of 2000.

- Report by Liben Gebremikael, Coordinator Refugee Resource, Woodpath Project dated 24 January 2003. In describing his background she noted that:

> “He also had active suicidal thoughts and had once attempted to commit suicide in the autumn of 2001. He has clearly expressed to me that if he was made to return he would rather kill himself here than face the harassment, torture and death at the hands of the gang members from whom he managed to escape in the past…. Mr Plaku has once attempted suicide here and this makes me take the threat of attempting against very seriously”.

The issue of real risk to this appellant

29. In the light of the above we now turn to the question of whether the adjudicator was entitled to conclude that the decision appealed against would not have the foreseeable consequence of exposing the appellant to a real risk of suicide or other significant detriment to his physical and moral integrity.

30. Working backwards, we see nothing unsustainable about her findings in relation to the availability of relevant medical facilities in Kosovo.

31. It is true that the UNHCR Position on the Continued Protection Needs of Individual from Kosovo Update of 2002 refers at paragraph a8 among others to persons with severe and chronic mental illness whose condition requires specialised medical intervention of a type not yet available in Kosovo. Such invididuals are said to be in a particularly vulnerable situation and may have

special needs that should be taken into account in the context of return in the present circumstances.

32. It is also true that the CIPU materials are essentially confined to descriptions of the medical facilities that are available. Paragraph 5.39 of the October 2002 Assessment records that:

> "Although mental health provision in Kosovo is relatively undeveloped, treatment for psychological conditions including Post Traumatic Stress Disorder in available in Kosovo. Details of the "Kosovo Rehabilitation Centre for Torture Victims (KRCT)" which provides treatment for PTSD are included in the source materials"."

33. However, paragraph 5.38 does mention that a review of the EWHO mental health project in July 2002 made a positive evaluation of the progress in mental health sector in Kosovo. It goes on to state that: "The WHO mental health programme has impacted on the development of a comprehensive mental health strategy developed in collaboration with local mental health processionals…".

34. Certainly there is no current evidence we have been made aware of that mental health facilities have been considered of poor quality or as seriously deficient or as unlikely to ensure intensive treatment of a mental health condition when that was required. Furthermore, it appears that particular steps have been taken to cater for the needs of persons who have been victims of trauma.

35. This brings us to the issue of assessment of the appellant's mental health in consequence of a removal to Kosovo.

36. The grounds contend that the adjudicator was wrong to approach the assessment of risk upon return to this appellant by reference to factors such as his character and progress in this country. We cannot agree. As we have already seen, "social performance" factors relating to personal conduct and the quality and extent of a person`s engagement with the external world, through friends, study and work etc are clearly much to the fore in DSM-IV- based diagnoses.

37. It is true that the ICD10, F32 criteria, as set out by Annette Goulden as an Appendix to her March 2002 report, appear more cautious, stating:

> "Differentiation between mild, moderate, and severe depressive episodes rests upon a complicated clinical judgement that involves the number, type, and severity of symptoms present. The extent of ordinary social and work activities is often a useful guide to the likely degree of severity of the episode, but individual, social and cultural influences that disrupt a smooth relationship between severity of symptoms and social performance are sufficiently common and powerful to make it unwise to include social performance amongst the essential criteria of severity".

38. However, irrespective of the extent to which social performance factors played a part in Dr Goulden`s assessment (or should have), the question the adjudicator had to ask was one about the impact on the appellant of any removal to Kosovo. Factors relating to his ability to cope with social relationships and to pursue normal activities such as study and work and sharing living accommodation with other people were plainly relevant to that assessment.

39. This brings us directly to the issue of the risk of suicide.

40. We would note two particular features of the medical evidence relating to this issue.

41. One is that it falls short of stating that the appellant represents a real suicide risk regardless of his location. Indeed, it maintains that the appellant`s current environment in the UK is assisting him in maintaining the level of psychological equilibrium he does have.

42. Another is that in alluding to problems the appellant would face upon return, the report is somewhat equivocal. It contains passages which appear to state that the mere fact of return to the appellant`s country (Federal Republic of Yugoslavia) would psychologically destabilise the appellant. But its underlying logic would appear to be that return there is only seen to give rise to a real risk of suicide because: (i) within that country there is the place where the appellant suffered the events which caused him to become traumatised; (ii) having to return to such a place would compel him to re-experience that trauma in a way he could not cope with (in Annette Goulden`s words, "[f]acing the traumatic past without the support of a stable home environment, social network and therapeutic setting may be intolerable and precipitate a severe avoidance reaction such as suicide"); and (iii) he would not have the necessary medical and social support in order to ensure he can cope.

43. As regards (i) and (ii), we would not question that return to Kosovo will cause the appellant to recall traumatic events in a different way than he does at present: he will be back in the country where his traumatic experiences occurred. But we do not see that the mere fact of return to the *country* of Federal Republic of Yugoslavia or to the *region* of Kosovo entails that the appellant will be compelled to revisit the *scene* of his trauma in the village of Matcan, north-east of Pristina. For one thing the appellant, whatever he subjectively believes now, will see for himself upon arrival in Kosovo that the Serbs no longer pose a threat to ethnic Albanians in Kosovo and that there had been a considerable improvement in the political and security situation in Kosovo. None of the medical evidence suggests that he would be incapable of perceiving such realities. For another it will be entirely a matter for him whether he chooses to visit his old house or the village of Matcan: indeed, it is implicit in what is said in the medical reports that he will not want to revisit the scene of his trauma for some considerable time, if ever.

44. Viewed in this light it is clear that the principal medical reports wrongly equated return to a country with return to a scene of trauma. Thus, to the extent that the medical reports postulated a re-exposure to the scene of the trauma, they go well beyond the limits of a realistic appraisal. So long as the appellant seeks medical help when he returns, and again the medical evidence does not suggest he would not seek medical help, his return will not be to the scene of his trauma but into the hands of medical and related services whose focus will be on treating his trauma, not re-activating it. Those administering the medical help will be persons very familiar with victims of trauma arising out of the Kosovan conflict.

45. As regards (iii), we would accept that the appellant currently enjoys medical and social support to a good standard. But it is sufficiently clear that he has managed to cope well enough with his trauma to attend college, train as a chef and conduct social relationships. When he returns to Kosovo he will not have (so far as we are aware) any family support network. But when he returns, no longer as a minor, we consider that his demonstrated ability to engage with the external world will stand him in good stead there. Indeed, since he will be returning to his own culture to live among people of the same ethnic background and, in addition, will be able to access adequate medical facilities and receive assistance with finding housing and employment, we do not consider that he will in fact have to face conditions anywhere near as adverse as those which the medical reports appear to presuppose.

46. Accordingly, In view of the question the adjudicator had to decide, we consider it was entirely open to her to conclude that return would not expose the appellant to a real risk of suicide or to any other type of serious or significant detriment to his physical and moral integrity. We further consider that in this regard she was perfectly entitled to attach significant weight to the evidence relating on the one hand to the appellant`s ability to cope with normal daily functions presently and on the other hand to the relatively positive conditions he would actually face in Kosovo.

47. For the above reasons this appeal is dismissed.

DR H H STOREY
VICE-PRESIDENT