Neutral Citation Number: [2021] EWHC 610 (Admin)

Case No: CO/1143/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/03/2021

Before:

MR JUSTICE CHAMBERLAIN

- -

Between:

IVOR FLETCHER	**Appellant**
- and -	
GOVERNMENT OF INDIA	**Respondent**

- -
- -

BEN KEITH (instructed by **Lloyds PR Solicitors**) for the **Appellant**
JAMES STANSFELD (instructed by **Crown Prosecution Service**) for the **Respondent**

Hearing dates: 28 January 2021

- -

Approved Judgment

MR JUSTICE CHAMBERLAIN :

Introduction

1 The Appellant, Ivor Fletcher, is sought by the Government of India to serve a 10-year sentence of imprisonment imposed following his conviction on 23 May 2005 for an offence of possession of 10 kg of charas (a form of cannabis) committed on 12 April 2002.

2 The Indian Government's extradition request was made on 22 March 2018 and certified on 18 June 2018. It provided an assurance about prison conditions and some further information.

3 There was a contested extradition hearing before District Judge Zani at Westminster Magistrates' Court on 10 and 14 October 2019. The hearing was adjourned to allow the parties to file written submissions. The District Judge handed down his judgment on 13 January 2020. He decided that there were no bars to extradition and sent the case to the Secretary of State.

4 On 8 March 2020, the Secretary of State ordered the Appellant's extradition pursuant to s. 93(4) of the Extradition Act 2003 ("the 2003 Act").

5 The Appellant appealed under s. 103 of the 2003 Act against the decision of the District Judge. There was no separate challenge to the decision of the Secretary of State.

6 On 19 October 2020, Sir Duncan Ouseley, sitting as a Judge of the High Court, granted permission on a single ground: that the District Judge was wrong to conclude that extradition was not unjust and oppressive for the purposes of s. 91 of the 2003 Act due to the Appellant's mental health. He also granted the Appellant permission to adduce an expert report dated 14 September 2020 by Dr Andrew Forrester, a consultant forensic psychiatrist.

Background

7 The Appellant was arrested in Himachal Pradesh in 2002. He was remanded in custody for some 18 months before being acquitted after a trial. He was ordered not to leave India pending a prosecution appeal. On 23 May 2005, the High Court of Himachal Pradesh convicted the Appellant and sentenced him to 10 years' imprisonment. He was ordered to surrender to the trial court within four weeks of the judgment. Instead, he crossed the border into Nepal, from where he returned to the UK on 7 July 2005.

8 In the Appellant's absence, his legal representatives filed an appeal against conviction and applied for bail to the Supreme Court of India. The Court refused bail on 5 December 2005 and his legal representative was ordered to file proof of surrender.

9 In light of the Appellant's failure to surrender, an arrest warrant was issued on 8 May 2007 and the Supreme Court formally dismissed the Appellant's appeal on 23 August 2011. Once the Appellant was located in the UK, the arrest warrant was updated on 22 March 2017. The Appellant was eventually arrested on 18 June 2018.

The evidence before the District Judge

10 The Appellant relies upon the evidence of Dr Andrew Forrester, a consultant and honorary senior lecturer in forensic psychiatry. The Respondent adduces no evidence of its own.

11 Dr Forrester produced an initial report dated 20 March 2019.

12 The report sets out a history of mental illness dating back to 2009 or 2010. The medical records show several suicide attempts, the most recent in February/March 2016. There is a significant history of support from mental health services. On examination, the Appellant had numerous scars from healed self-harm cuts of varying sizes on his torso and arms. He reported having planned methods of suicide in the event of his extradition.

13 Dr Forrester set out the Appellant's description of his experience in prison in India. It included overcrowded and insanitary conditions, rationing of water and violence from detainees and guards. He believed that, as someone who had absconded from India, the authorities would break his legs if he were returned to prison in India.

14 Dr Forrester concluded that the Appellant presented with a diagnosis of recurrent depressive disorder, current episode moderate, without psychotic symptoms. There was also a background diagnosis of moderate personality disorder, with emotionally unstable and dissocial elements. Dr Forrester said this:

> "10.10 Ivor Fletcher also has a history of self-harming behaviour that has previously been closely linked with the mental disorders from which he suffers. Impulsivity appears to have been a particular issue, as it often is with people who present with traits of emotionally unstable personality disorders, in both his previous self-harming behaviour and in his previous suicidal acts. This background of recurrent self-harming and suicidal thoughts and behaviour, upon background diagnoses of depression and personality disorder, indicates that there is an elevated risk of suicide in this case.
>
> 10.11 Each of these factors - depression, personality disorder, history of self harming and suicidal thoughts and behaviour - is, on its own, associated with an elevated risk of suicide, however the risk is likely to be further enhanced when they appear together, as in Ivor Fletcher's case.
>
> 10.12 When they are also associated with specific suicidal ideas and plans that have been researched, as described by Ivor Fletcher in section 9 of this report, in my opinion the risk of suicide should then be considered substantial. In my view, the risk of completed suicide is likely to be greatest in the period following an extradition decision and, given the statements he has made, likely to persist during the period of preparation for removal, while in transit, and after arrival in prison in India.
>
> …

> 10.14 Ivor Fletcher cites the treatment he received in Indian prisons, the conditions he experienced there, and his belief that he will be physically harmed by having his legs broken if he is returned to India, as a key factor in his suicidality. When this is taken at face value, it appears that Ivor Fletcher is able to think through how and when he will act, however an important factor to consider is the influence of his underlying personality disorder which introduces a strong element of impulsivity. In my opinion, and despite the plans Ivor Fletcher has described, it is likely that any future suicidal acts will be underlain with this impulsivity, arising from underlying personality disorder, as they appear to have previously been."

District Judge Zani's findings and conclusions

15 In his judgment, District Judge Zani found that:

(a) The Appellant had suffered from mental health issues for some years, but had been able to cope with living independently and continued to take appropriate prescription medication. There was no evidence that such medication would be either unavailable or not prescribed by the Indian prison authorities: [84], [103];

(b) There had been no reported incidents of either hospitalisation, self-harm or attempts on the Appellant's life since his arrest in the UK on 7 November 2018: [85];

(c) Personality disorder and depression are "not particularly uncommon, not only within the prison estate, but also within the wider society generally": [86];

(d) The Appellant's expert witnesses (Dr Mitchell and Dr Forrester) had not been able to provide the court with "any meaningful information" regarding the anticipated psychiatric care and assistance that will, or may, be made available to the Appellant upon extradition being ordered: [87];

(e) The Appellant had attributed the origins of his mental health conditions to a period in an Indian prison from April 2002 until June 2003. However, the weight of this evidence was reduced by the fact that the Appellant did not give oral evidence and, accordingly, was not cross-examined: [88]-[93];

(f) Since returning to the UK in 2005 the Appellant had experienced multiple breakdowns, including an admission to a psychiatric ward and episodes of self-harm: [93], [98], [100].

16 The District Judge concluded at [105]:

> "I am entirely satisfied that the Indian authorities know their obligations to deal appropriately with such medical issues as the Appellant may present, and that they will abide by such obligations. Accordingly, such challenge under s. 91 of the 2003 Act must fail".

Dr Forrester's supplementary report of 14 September 2020

17 Dr Forrester prepared a supplementary report after an examination by videolink on 24 August 2020. In it, he confirmed that the Appellant was currently taking mirtazapine (an antidepressant). His GP had recorded on 19 May 2020 that he had no plans or thoughts regarding self-harm.

18 Dr Forrester described what the Appellant had said to him as follows:

> "9.8 He then told me that he has been feeling depressed recently and that this has been worse since lockdown commenced in March 2020. He said that he feels depressed 'every day', that it is 'always there', and that it is exacerbated by visiting his father.
>
> …
>
> 9.20 I asked him if he had been having any thoughts of self harm or suicide and he replied to say he had been experiencing suicidal thoughts on a daily basis. By his own account, 'I'm only holding on because there is a glimmer of hope… my confidence… is draining away.'
>
> 9.21 He then said that he has considered how he might kill himself, stating that 'I've got a lot of quetiapine left' and 'cutting… I know where the veins are, don't have to dip deep for arteries… cut one of them and bleed out.'
>
> 9.22 I asked him how he would respond if extradition was ordered and he replied to say he 'would cut and bleed… I see it as… if I was to let them do that to me, I don't think I would survive then ten years… given the conditions in there… my health.'
>
> 9.23 He said that he does not see a future for himself in the event of extradition, stating that 'I'd be homeless, without any money, without a State pension, that's a pretty dire future… what's the point of going there to spend my last days in an Indian jail… I figure why suffer for all of that time… at least if I take action to end my life, I decide when and how… better than getting killed in a jail.'

19 Dr Forrester diagnosed the Appellant as suffering from "recurrent depressive disorder, current episode severe, without psychotic symptoms" (para. 10.2) and a "moderate personality disorder" (para. 10.3). He concluded:

> "10.7 I remain of the opinion, as outlined in paragraph 10.11 of my earlier report in this case, that each of the identified factors in this case – depression, personality disorder, history of self harming and suicidal thoughts and behaviour – is, on its own, associated with an elevated risk of suicide, and that the risk is likely to be further enhanced when these features appear together, as they do in Ivor Fletcher's case.
>
> 10.8 An additional factor to consider is Ivor Fletcher's age. He is aged 57 and it is known that suicide rates are increased in middle aged and older men

> 10.8 Ivor Fletcher currently describes the presence of suicidal thoughts on a daily basis, with suicidal intentions and specific plans should extradition proceed. Despite this, he has also said that 'no immediate threat' arises, largely because he still thinks 'there is a glimmer of hope' (by which I understand him to mean that he is awaiting the outcome of this appeal).
>
> 10.9 However, despite this partial reassurance, I am of the opinion that his risk of suicide should presently be considered very high. This is because he presents with a number of risk factors, including severe depression, personality disorder (with a resulting strong element of impulsivity which he is unable to control), a history of self-harming behaviour and suicidal acts, and because he has described the presence of daily suicidal thoughts, with both suicidal intentions and specific plans.
>
> 10.10 Given this risk, I have written to Ivor Fletcher's GP, with his consent, to communicate what I believe is a very high risk of completed suicide.
>
> 10.11 In my opinion, the risk of completed suicide is likely to rise sharply if he loses this appeal and it is likely to remain very high during the period of preparation for removal, during removal itself, and following arrival in prison in India."

The assurances provided by the Respondent

20 During the course of these proceedings the Respondent has provided assurances and responses to requests for further information, including from: (i) the Ministry of Home Affairs of the Government of India on 20 March 2019 ("the Assurance"); (ii) the Director General of Prisons & Correctional Services Himachal Pradesh on 2 July 2019 ("FI-3"), 26 June 2019 ("FI-4"), 5 November 2020 ("FI-5"), 9 December 2020 ("FI-6"); and (iii) the Superintendent of Police of the District of Kullu ("FI-7").

21 Taken together, these are to the effect that:

(a) On arrival in India, the Appellant will be assessed by appropriate mental health professionals and appropriate steps will be taken to ensure his timely psychiatric assessment and treatment (see FI-4). He will be assessed by a medical professional on his arrival at Model Central Jail, Kanda. The timing and location of the assessment will be decided by the medical professional. He will be transferred with an "adequately strong escort team" (which may include a psychiatrist or psychologist) from the airport to prison (see FI-7).

(b) The Appellant will be held at the Model Central Jail, Kanda, District Shimla, Himachal Pradesh (see the Assurance). On arrival at the prison, he will be confined to a "safe barrack under strict watch and vigil" (see FI-5). This has iron grills and railings fixed on all doors, windows etc., instead of wood or glass or other material, and the inmates are unable to get access to ceiling fans or electric wires. These measures are intended to prevent suicide attempts from, for example, jumping from the barrack. The safe barrack is located near the Head Warder's room, so that a strict vigil can be kept on movements within the barrack. The barrack has capacity for 12 inmates, with six windows for adequate

light and ventilation and inmates are outside of the barrack during the daytime and are able to move within their block (see FI-6).

(c) The Superintendent of the Jail could decide to transfer the Appellant from the safe barrack to a normal cell or barrack (see FI-6). The cells in both type of barracks are 520 square feet, with a capacity of 12 inmates. Thus, each inmate has more than 4 sq. m. Photographs are provided (see the Assurance; FI-4; FI-6).

(d) The Appellant will have access to all the healthcare facilities in the prison, which includes a medical officer and associated para-medical staff. Presently there are no psychiatric staff posted in the jail (see FI-5). However, if needed, the Appellant could receive specialist psychiatric care and treatment at IGMC Shimla, which is located nearby (see FI-3). The psychiatric team from IGMC Shimla pays periodic visits to the jail (see FI-5).

(e) Any decision to transfer the Appellant to the prison hospital will be taken by the Superintendent on the recommendation of the medical authority. The Appellant will be able to remain at IGMC Shimla for as long as medically advised (see FI-6).

(f) The Department of Prisons and Correctional Systems provides medication, free of cost, as required to treat any physical health condition during the Appellant's detention (FI-4), including his current medication mirtazapine (FI-6). He will also be provided with any medicines and therapy prescribed by Medical Officers/Psychiatrists (FI-5).

(g) Persons at risk of suicide at the Model Central Jail are kept under "strict watch and vigil" and confined in the safe barracks (see sub-para. (b) above). They are "continuously provided with psychiatric treatment from IGMC Shimla. They are also kept busy in other Jail Welfare Activities" (see FI-5). The Appellant will be permitted to go outside the cell for six hours every day with access to yoga classes, open air gym, library etc. (see the Assurance) (see FI-6).

22 The Respondent submits that, between them, these assurances are sufficient to address the suicide risk.

The evidence about prison conditions

23 The Appellant relies on the reports of Mr Arjun Sheoran (dated 10 June 2019) and Dr Alan Mitchell (who reported initially on 23 April 2019 and then in a supplemental report on 17 January 2021).

24 Mr Sheoran is an Indian-qualified lawyer. District Judge Zani was satisfied that he had sufficient expertise relating to Indian criminal law to be considered an expert: see [16] of the judgment below. Relying upon open-source materials, Mr Sheoran expressed concerns about prison conditions, in particular with respect to overcrowding. I share District Judge Zani's reservations (see [17] of the judgment below) about the weight to be placed on his evidence, given that Mr Sheoran practices in a different State from that where the Appellant would be detained and apparently had no first-hand knowledge of conditions within the relevant prison.

25 Dr Mitchell has monitored prison conditions since 1996 in Scotland and since 2002 internationally. He is currently Chair of the Independent Prison Monitoring Advisory Group for Scotland and an elected member of the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Dr Mitchell's experience means that his conclusions deserve considerable weight. For present purposes, Dr Mitchell's supplementary report contains the most relevant evidence. The view expressed there was that the further information provided by the Respondent provides inadequate reassurance that the Appellant's mental health problems, including a heightened risk of suicide, could or would be appropriately managed at the Model Central Jail, Kanda. The information provided is said to be insufficient in three key respects: first, the description of the "safe barrack"; second, the details as to the level of supervision; third, the details as to the psychiatric care provided at IGMC Shimla.

Legal framework

26 India is a Category 2 territory. Section 91 of the 2003 Act applies to extradition requests by such territories. It provides:

> "(1) This section applies if at any time in the extradition hearing it appears to the judge that the condition in subsection (2) is satisfied.
>
> (2) The condition is that the physical or mental condition of the person is such that it would be unjust or oppressive to extradite him.
>
> (3) The judge must—
>
> (a) order the person's discharge, or
>
> (b) adjourn the extradition hearing until it appears to him that the condition in subsection (2) is no longer satisfied."

27 In *Jansons v Latvia* [2009] EWHC 1745 (Admin), the appellant had medical diagnoses of depressive illness and post-traumatic stress disorder, coupled with a long history of severe self-harm. The PTSD arose from a previous experience of prison in Latvia, where he was assaulted [15]. The day after extradition was ordered by the District Judge, the appellant made a serious attempt to commit suicide in custody which very nearly succeeded. There was uncontested psychiatric evidence that, if he were extradited, he would attempt suicide with a high likelihood of completion: [2], [13]-[15]. The Divisional Court (Sir Anthony May P and Dobbs J) concluded as follows at [29]:

> "It would… be oppressive to order his return when there is, on any view on the evidence, such a substantial risk that he will commit suicide. It is not as if this is an appellant who is threatening to commit suicide without any history of having tried to do so. Not only is he threatening that he will commit suicide and the doctor believes him but he has in fact, for the same reason, attempted to commit suicide in Wormwood Scrubs Prison and very nearly succeeded in doing so. In reaching the conclusion that it would be

> oppressive to return him, this is not a reflection on the ability of the Latvian prison authorities to protect him and provide the necessary treatment. But an assessment, so far as the evidence enables one to do so, that the risk that he will succeed in committing suicide, whatever steps are taken, is on the evidence, sufficiently great to result in a finding of oppression…."

28 In *Turner v Government of the USA* [2012] EWHC 2426 (Admin), the appellant attempted suicide two days before judgment was given in her appeal: [15]-[16]. Aikens LJ (with whom Globe J agreed) summarised the correct approach as follows at [28]:

> "(1) The court has to form an overall judgment on the facts of the particular case…
>
> (2) A high threshold has to be reached in order to satisfy the court that a requested person's physical or mental condition is such that it would be unjust or oppressive to extradite him…
>
> (3) The court must assess the mental condition of the person threatened with extradition and determine if it is linked to a risk of a suicide attempt if the extradition order were to be made. There has to be a 'substantial risk that [the Appellant] will commit suicide'. The question is whether, on the evidence the risk of the Appellant succeeding in committing suicide, whatever steps are taken is sufficiently great to result in a finding of oppression…
>
> (4) The mental condition of the person must be such that it removes his capacity to resist the impulse to commit suicide, otherwise it will not be his mental condition but his own voluntary act which puts him at risk of dying and if that is the case there is no oppression in ordering extradition…
>
> (5) On the evidence, is the risk that the person will succeed in committing suicide, whatever steps are taken, sufficiently great to result in a finding of oppression?...
>
> (6) Are there appropriate arrangements in place in the prison system of the country to which extradition is sought so that those authorities can cope properly with the person's mental condition and the risk of suicide?
>
> (7) There is a public interest in giving effect to treaty obligations and this is an important factor to have in mind."

29 On the facts, the question whether the appellant's mental health was such that it would be oppressive to extradite her was "finely balanced": [41]. There had been only two previous episodes of self-harm: [42]. Unlike in *Jansons,* the attempted suicide was "a carefully controlled one", made after a rational review of choices and with her mother and sister in the house so that they could easily find her: [43]. If there were any further attempts at suicide, this would be the result of a deliberate choice: [44]. The predicted deterioration in mental state would be the result of the trial process, not fears of mistreatment in prison triggering PTSD: [45]. There were steps that could be taken to decrease the risk of suicide or attempted suicide in the period between the dismissal of

the appeal and the implementation of the extradition order: [46]. There was evidence that prisoners often say they will commit suicide, but this view can change: [47]. The appellant's fear that she would not get a fair trial had no rational basis: [48]. It followed that the high threshold for oppression was not met: [49].

30 In *Wolkowicz v Polish Judicial Authority* [2013] EWHC 102 (Admin), [2013] 1 WLR 2402, at [9], the Divisional Court (Sir John Thomas P and Burnett J) endorsed Aikens LJ's summary of the correct approach to suicide cases. At [10], he said this:

> "The key issue, as is apparent from propositions (3), (5) and (6), will in almost every case be the measures that are in place to prevent any attempt at suicide by a requested person with a mental illness being successful."

31 *Wolkowicz* considered three joined cases:

(a) The first involved conflicting reports from three psychiatric experts; two of whom gave oral evidence at trial [30ff]. The clinical view of the expert whose evidence was preferred by the trial judge was that the appellant had no psychiatric disorder or depressive illness and that there was a low to medium suicide risk upon extradition: [34]. He had attempted suicide by overdose in a custodial setting approximately a month before the Divisional Court hearing, but even assuming there was a high risk or suicide there was nothing to suggest that effective steps could not be taken to mitigate the risk by authorities either in the UK or in the requesting state: [39].

(b) In the second case, the appellant relied on an expert report which his own legal representative conceded did not meet the high threshold of "oppression": [48]. As such, there was no basis for contending that his condition could not be properly managed by the requesting state, notwithstanding his chronic delusional disorder: [56].

(c) In the third case, the Senior District Judge concluded that there was no credible evidence of attempted suicide or self-harm for the 18 months that the appellant had been in the UK and that her expert was "unable to be dispassionate" and "had applied his own definition of 'oppression'": [64], [68]. The Divisional Court held that in light of the evidence of treatment and facilities in the requesting state, it seemed "impossible" to contend that the trial judge was not entitled to reach her conclusions of the facts [73].

32 In *Farookh v Germany* [2020] EWHC 3143 (Admin), Fordham J addressed the relationship between *Turner* propositions (3), (5) and (6), holding at [7] that:

> "… the question in Proposition (3) is to be approached as the ultimate determinative question – when Proposition (3) is read with propositions (5) and (6) – is as follows (the encapsulation is mine):
>
> > The question is whether, on the evidence, whatever steps are taken – and even if the Court is satisfied that appropriate arrangements are in place in the prison system of the country to which extradition is sought so that those authorities will discharge their responsibilities to prevent the

> requested person committing suicide – the risk of the requested person succeeding in committing suicide, by reason of a mental condition removing the capacity to resist the impulse to commit suicide, is sufficiently great to result in a finding of oppression.
>
> As it seems to me, this composite approach makes best sense of the phrase 'whatever steps are taken' in Turner propositions (3) and (5). It is a mistake to treat the Turner Propositions as being a sequential flowchart – like a 'route to verdict' – such that Proposition (6) provides an answer notwithstanding that the 'question' described in Proposition (3) has previously been answered 'yes'. Putting the same point another way, the phrase 'so that those authorities can cope properly with' in Proposition (6) would need to entail 'steps' being 'taken' which will reduce the risk so that it is no longer 'sufficiently great to result in a finding of oppression' for the purposes of Proposition (3) and (5)."

33 On the facts, the appellant had clinical diagnoses of severe PTSD, anxiety and depression, as well as a history of drug and alcohol misuse. At least two "genuine and concerted" suicide attempts were recorded in the year prior to the hearing: [16], [19]. Fordham J held that the key components in the case were "materially identical" to those in *Jansons* and, in one respect, stronger given that the Respondent did not challenge the expert's assessment that the suicide attempts were genuine during cross-examination: [17], [26]. The uncontested expert evidence was that it was "highly probab[le] that he will eventually succeed in taking his life" if extradited to Germany: [20]. Accordingly, Fordham J concluded that (at [26]):

> "… Notwithstanding the ability of the German authorities to discharge the responsibilities by making appropriate arrangements, on the evidence such is the mental condition of the Appellant linked to the risk of suicide – where the condition is such as to remove the capacity to resist a suicidal impulse – that the risk of the Appellant succeeding in committing suicide, whatever steps are taken, is sufficiently great to result in a finding of oppression…"

34 Both Mr Keith (who appeared for the Appellant) and Mr Stansfeld (who appeared for the Respondent) invited me to accept Fordham J's analysis and encapsulation in *Farookh*, subject in Mr Stansfeld's case to a reservation about the last sentence of [7], which he submitted would conflict with [10] of *Wolkowicz* if treated as a general proposition applicable in every case.

Submissions

35 Mr Keith submits that the Appellant's extradition would be oppressive. On Dr Forrester's uncontested evidence, the Appellant is at "very high" risk of completed suicide as a result of severe and long-term mental illness. The risk is real and exacerbated by the extradition proceedings. The evidence suggests that impulse would play an important part and that he would be unable to resist the impulse because of his personality disorder. As in *Farookh*, the risk is so high that it would be oppressive to extradite the Appellant even if the assurances were satisfactory.

36 In any event, Mr Keith submits that the Respondent has not provided satisfactory assurances. The conditions in Indian prisons are poor and the assurances provided fall "significantly short" of showing a credible treatment or protection regime. In particular, there are no on-site psychiatric facilities, psychiatrists or mental health professionals at the Model Central Jail and the facilities at IGMC Shimla are a significant distance from the prison. Particularly reliance is placed on Dr Mitchell's evidence that the "safe barrack" is not adequately designed to minimise the risk of a prisoner taking their own life.

37 Mr Stansfeld submits that the test of oppression under s. 91 is not made out, because the Appellant has not established that he will be unable to resist an impulse to commit suicide as a result of a mental condition. The Respondent points to evidence that the Appellant had an apparent timescale and options for any potential suicide attempt and submits that is suggestive of an exercise of control over an intention to commit suicide. Given that any suicide attempt by the Appellant would be a conscious and voluntary act, his extradition is not oppressive.

38 In any event, the Appellant has not established that the risk of suicide is so high that state authorities will be unable to provide sufficient care for the Appellant in a custodial setting. The Respondent's assurances are specific and adequate.

Discussion

39 The starting point for approaching the application of s. 91 in cases where a risk of suicide is asserted is Aikens LJ's judgment in *Turner*, at [28]. It is necessary to consider first the risk of completed suicide absent preventive measures. If this risk exceeds the high threshold for oppression, the next question is whether the person's mental condition removes his capacity to resist the impulse to commit suicide. If that question is answered in the affirmative, as the Divisional Court said in *Wolkowicz* at [10], the key issue "in almost every case" will be the measures in place to prevent suicide in the requesting State. This is because, in almost every case, proper preventive measures will reduce the risk of completed suicide below the high threshold required for oppression. However, the use of the word "almost" recognises that there may be cases (such as *Farookh*) where adequate measures are in place, but extradition would still be oppressive because the risk of completed suicide is nonetheless too great. Thus, I would endorse as a correct statement of the test the compendious question posed by Fordham J in *Farookh*:

> "whether, on the evidence, whatever steps are taken – and even if the Court is satisfied that appropriate arrangements are in place in the prison system of the country to which extradition is sought so that those authorities will discharge their responsibilities to prevent the requested person committing suicide – the risk of the requested person succeeding in committing suicide, by reason of a mental condition removing the capacity to resist the impulse to commit suicide, is sufficiently great to result in a finding of oppression".

40 As is apparent from this formulation, the ultimate question is an evaluative one: is the risk *sufficiently great* to result in a finding of oppression? That question cannot be considered in the abstract. In answering it, or perhaps in deciding where the threshold

is, it is important to consider the public interest in giving effect to treaty obligations: see *Turner* proposition (7).

41 Having set out the evidence and the facts and principles derived from the authorities in some detail, I can express my conclusions on the issues I have to decide relatively briefly:

(a) The cases in which the test for oppression has been found to be met on the basis of risk of suicide (*Jansons* and *Farookh*) have involved recent, genuine suicide attempts. Where there have been such attempts, these will be relevant to the conclusion about future risk. But the assessment of future risk of completed suicide (the starting point for oppression) is a matter for expert evaluation and involves consideration of a wide range of factors, of which the history of attempts is only one.

(b) In this case, although there has been no attempted suicide since 2016, there is uncontested expert evidence that the Appellant presents a "very high risk" of completed suicide, given the combined effect of: (i) his severe depression; (ii) his personality disorder; (iii) his history of self-harming behaviour and suicidal acts; and (iv) the reported presence of daily suicidal thoughts, with both suicidal intentions and specific plans. Giving due weight to the public interest in honouring the UK's treaty commitments, this would be sufficient to meet the high threshold for oppression unless preventive measures would reduce the risk below that threshold.

(c) The Appellant's description to Dr Forrester of his plans to commit suicide suggest that his current suicidal thoughts arise in the context of a rational consideration of the predicament he believes he will face in prison in India and his inability to cope with that predicament. However, that does not mean that any attempt to commit suicide will be "voluntary" in the sense described in *Turner*. On the evidence, there are two mental disorders which play a part in the "very high risk" of completed suicide: depression and personality disorder. The latter is associated with a "strong element of impulsivity which he is unable to control", which underlay his previous self-harming and suicide attempts. In my judgment, the evidence of Dr Forrester establishes that the risk of completed suicide derives in substantial part from a mental disorder which "removes his capacity to resist the impulse to commit suicide" – i.e. *Turner* proposition (4) is satisfied.

(d) This means that the preventive measures are critical. The most important such measure is the "safe barrack" where the Appellant would be accommodated. FI-6 indicates that the main difference between the "safe barrack" and other cells is that it is configured so that prisoners cannot jump out of it to commit suicide. This involves using "proper iron [g]rills; [r]ailings" on "all its doors, windows, porch, stairs etc. instead of using wooden, glass or other material". Inmates also cannot have access to "ceiling fans and electric wire etc." It is 16ft x 32.5ft and has the capacity to house 12 inmates. I accept Dr Mitchell's expert evidence that this does not provide any reassurance that the barrack does not contain ligature points which could be used in suicide attempts. Although there is no evidence that the Appellant has used ligatures before, the evidence does suggest that he is determined to commit suicide if extradited. This makes it important that any

assurance should address all realistic modes of committing suicide. The assurances given here do not.

(e) The Indian authorities say in FI-6 that the safe barrack "should be near to the room of the supervisory staff inside the jail from where the supervisory staff can have a bird's eye view of this barrack and keep strict vigil upon the movements inside the barrack", that the safe barrack is located "near" the Head Warder Room and that "[t]he Jail watch and ward staff and supervisory staff deployed to watch and ward this barrack, will also keep strict watch and vigil upon Mr Fletcher by 24X7". But this does not explain: (i) how close the room of the supervisory staff is to the safe barrack; (ii) whether staff are able to make observations directly from their room and if so how; (iii) if not, how often they go to the safe barrack to observe prisoners and for how long; (iv) how many supervisory staff are present and how many prisoners they are required to supervise; (v) what measures are in place to supervise prisoners when they are locked out of the barrack during the day; (vi) what (if any) measures are in place to prevent prisoners having access to objects or implements with which they can self-harm or attempt suicide. These deficiencies mean that the information provides little reassurance that the measures in place would significantly reduce the risk of completed suicide from the "very high" level which Dr Forrester assesses the Appellant presents.

(f) I would not regard it necessarily problematic that the prison has no specialist psychiatric care available on-site, given the availability of such care at IGMC Shimla, some 20 km away. But I accept Dr Mitchell's evidence that the lack of detail as to the frequency with which psychiatrists from IGMC Shimla visit the jail means that it is difficult to assess the psychiatric care which would in practice be available. Certainly, the detail that is provided does nothing to allay the concerns about the extent of supervision to prevent suicide.

42 For these reasons, I have concluded that the assurances given do not significantly reduce the very high risk of completed suicide. Accordingly, on the evidence before the court (which is quite different from that before the District Judge), the physical or mental condition of the Appellant is such that it would be oppressive to extradite him. The appeal therefore succeeds.