Neutral Citation Number: [2024] EWHC 2210 (Admin)

Case No: AC-2024-LON-001933

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/08/2024

Before :

THE HONOURABLE MR JUSTICE BOURNE

- -

Between :

MICHAEL LOMAS	**Appellant**
- and -	
REPUBLIC OF SOUTH AFRICA	**Respondent**

- -

Rebecca Thomas (instructed by **Sonn Macmillan Walker**) for the **Appellant**
Adam Payter (instructed by **Crown Prosecution Service**) for the **Respondent**

Hearing date: 25 July 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on Friday 23 August 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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The Honourable Mr Justice Bourne :

Introduction and factual background

1. This is a "rolled up" hearing of applications to re-open the question of permission to appeal and, if permission is granted and it remains appropriate, to consider the substantive appeal, made on the grounds that the Appellant's extradition to South Africa would be oppressive under section 91 of the Extradition Act 2003 and/or would be a breach of his rights under ECHR Article 3.

2. The extradition request is governed by Part 2 of the 2003 Act. It arises out of allegations of bribery offences which are said to have occurred in South Africa between April 2015 and April 2017. The offences were described in the Court below as "serious and complex" and as being punishable with imprisonment for up to 15 years.

3. A final extradition hearing took place before District Judge Sternberg on 13 and 14 October 2022 and judgment was given in the Respondent's favour on 15 December 2022. The Secretary of State ordered extradition on 30 January 2023.

4. The extradition hearing was concerned with issues arising from the Appellant's health, both physical and mental.

5. So far as mental health was concerned, the DJ found:

   (1) The Appellant "suffers from depression, anxiety, insomnia and has received treatment for these symptoms and for suicidal thoughts in the past". He has had antidepressant medication, psychotherapy, psychological review and monitoring of his risk of suicide.

   (2) He would be "at a high or elevated risk of suicide in the event of his extradition" and that risk was high at the time of the hearing.

   (3) The DJ did not express a preference between the views of the two sides' expert witnesses, that his depression was "mild to moderate" (Respondent) or "moderate to severe" (Applicant).

   (4) There had been two past incidents when he walked out into the road, not caring whether he was hit by a car, in which he "demonstrated a reckless attitude to his personal safety".

   (5) He "has taken steps to plan suicide that go beyond ideation. He has put his affairs in order and has explored various methods by which he might seek to take his own life including ingesting poisonous berries, walking in front of a train and walking out on to a busy road".

   (6) In the event of extradition he should be referred to psychiatric services for review and given access to crisis and support help to properly monitor the risk of suicide, but if in custody at that time he would not require urgent transfer to a secure mental health unit.

(7) His extradition to South Africa would not give rise to injustice or oppression by reason of his mental health or suicide risk. The reasons for that finding are quoted here in full:

> "i. … I accept Dr. Picchioni and Dr. Poole's evidence that Mr. Lomas was suffering from moderate depression at the time of the hearing. That is consistent with the letter from Dr. Murray-Gane of 7 November that details events following the hearing. I also accept that he will need ongoing treatment for his depression and that his extradition would lead to an elevated risk of suicide and appropriate close monitoring will be needed should he be imprisoned in South Africa in order to ensure he does not harm himself or attempt suicide.
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> ii. I have noted the difficulty in characterising the incidents in which the requested person walked out into a busy road on two occasions in the past as being suicide attempts, for the reasons I have given above. However, Dr. Picchioni did characterise these incidents as suicide attempts and both psychiatrists agreed that the requested person had made plans to take his own life that go beyond suicidal ideation.
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> iii. However, whether or not those incidents are characterised as suicide attempts, and bearing in mind the context of Mr. Lomas' in-patient admission following the hearing, does not alter my conclusion on this ground. I am satisfied that appropriate monitoring and preventative measures will be put in place to properly manage any risk of suicide in the event of the requested person's surrender to South Africa. The South African authorities have already taken steps to remove ligature points from the cell in which it is proposed to hold him. They will provide regular monitoring whilst he is in his cell. He will be able to receive appropriate mental health treatment in the prison in the form of talking therapies and will also be able to receive treatment at the nearby hospital should he require it. Those steps demonstrate a positive and engaged attitude aimed at ensuring that the requested person is not able to harm himself or take his own life whilst detained in the unit where he will be held.
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> iv. The evidence before me is that, both before the extradition hearing and following his discharge from a period of voluntary in-patient admission, Mr. Lomas is not receiving any treatment for his mental health other than medication and some talking therapies. There is no evidence that his condition is so severe at present as to remove the impulse not to commit suicide. While it is possible that that his ability to control that impulse might be removed in future if his mental health deteriorates, I cannot say that this risk will crystalise. In any event, I accept that proper mental health treatment is available to him in the JCC in the event of his extradition and that, if necessary, he will receive treatment in the nearby hospital.
>
> v. In those circumstances, notwithstanding the level of the assessment of the risk that the requested person poses, I do not find that he will succeed in committing suicide whatever steps are taken. In particular, the availability of treatment for his mental health, together with an awareness of the risk that he

poses to himself, leading to regular observation in prison leads me to conclude he will not succeed in committing suicide whatever steps are taken.

vi. His mental condition is not currently such that it removes his capacity to resist the impulse to commit suicide and all that can be said is that it is possible that this may happen in the future.

vii. In any case, I am satisfied that there are appropriate arrangements in place both in this jurisdiction and in custody in South Africa to provide Mr. Lomas with appropriate treatment for his mental health, including in hospital if required so as to reduce the risk of self-harm and suicide that he might otherwise pose. I do not find that the evidence relied upon by the defence including the evidence of Ms. Costa Ramos and Dr. Poole undermines or negates the assurances that have been given, which I accept, nor, given those assurances, that conditions in prison or in hospital in South Africa are such as to render his extradition oppressive."

6. Permission to appeal was refused on the papers by Heather Williams J on 4 December 2023. There have since been a number of oral hearings.

7. Fordham J refused permission at an oral hearing on 23 February 2024[1], deciding that the section 91 and Article 3 thresholds were not arguably crossed by any of four "headline points", one of which was mental health and suicide risk ("the First Judgment").

8. On 20 March 2024 Fordham J allowed an application to re-open the appeal for the sole purpose of reconsidering the issue of fitness to fly[2] ("the Second Judgment"). All parties had previously taken the position that this was not a question for the Court at that time.

9. On 27 March 2024 Fordham J refused permission to appeal for a second time, having concluded that concerns raised by expert witnesses about physical health condition and fitness to fly did not reach the threshold of inhuman or degrading treatment for the purpose of Article 3 or engage section 91 of the 2003 Act[3] ("the Third Judgment").

10. The Appellant underwent spinal surgery in April 2024 and then made a further application for permission to appeal, filed as a subsequent human rights appeal by reference to section 108 of the 2003 Act. This was listed for a rolled up hearing. The oral hearing took place on 14 May 2024. On 21 May 2024 Fordham J again refused permission, finding no arguable ground of appeal based on a change in circumstances or new evidence relating to physical health condition and fitness to fly[4] ("the Fourth Judgment").

11. At a medical visit on 14 May 2024 the Appellant told a doctor that he would commit suicide if he were extradited. He was seen on 5 June 2024 by a psychiatrist, Dr Bradley Hillier, who provided a letter that day and a report on 6 June. On 7 June the

[1] [2024] EWH 388 (Admin)
[2] [2024] EWHC 637 (Admin)
[3] [2024] EWHC 731 (Admin)
[4] [2024] EWHC 1141 (Admin)

Appellant filed a further subsequent human rights appeal by reference to section 108, again on the basis of change of circumstances and new evidence. The grounds of appeal raised mental health and suicide risk, and a skeleton argument dated 11 June again relied on physical health condition and fitness to fly.

12. An oral hearing took place on 13 June 2024 before Fordham J. On 24 June 2024[5] ("the Fifth Judgment") he refused permission for the renewed ground based on physical health and fitness to fly, but directed this one-day rolled-up hearing to deal with the ground of mental health and suicide risk. He noted that in the Fourth Judgment he had referred to the report of a Dr Mitchell, recording that the Appellant had said that "if extradited he would take his own life and knew how he would do so", though suicide risk was not relied on at that hearing on the basis that the evidence at that time could not reach the high legal threshold for a submission of that kind. Fordham J said:

> "What I am envisaging is that the Court will be able to consider, particularly with reference to Stages 1 and 2[6] and the latest evidence, questions as to: whether and to what extent the suicide risk arises by reason of extradition or independently of it; whether suicide would be a voluntary act; whether appropriate steps have been identified; and whether the risk is so high, whatever steps are taken, as to constitute oppression. The parties will want to ensure that all questions have, promptly and fully, been addressed."

13. There have been subsequent proceedings relating to bail. On the Respondent's application, on 5 July 2024 DJ Sternberg revoked bail, noting that the evidence indicated a high risk of suicide which he considered could not properly be managed in the care home where the Appellant was residing. On 18 July 2024 Cavanagh J allowed an appeal against that decision, maintaining bail on the same terms as before.

Legal framework

14. Section 91 states:

> "91 Physical or mental condition
> (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 that the condition in subsection (2) is no longer satisfied."

[5] [2024] EWHC 1642 (Admin)
[6] These are references to the pre-transfer and transfer stages of an extradition case.

15. Article 3 ECHR provides: "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." It makes it unlawful for the UK to extradite an individual to a country where he is foreseeably at real risk of being treated in a manner prohibited by Article 3 (see, for example, *R (Ullah) v Special Immigration Adjudicator* [2004] 2 AC 323, §24). A Requested Person must establish that there are "substantial grounds for believing that there is a real risk of ill-treatment" of the requisite degree of severity in the receiving state.

16. A high threshold must be reached for a requested person's mental health to serve as a bar to extradition. In *Turner v Government of the USA* [2012] EWHC 2426 (Admin) Aikens LJ summarised the propositions which could be derived from the authorities 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 whether it is linked to a risk of a suicide attempt if the extradition 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) The court must decide whether, on the evidence, the risk that the person will succeed in committing suicide, whatever steps are taken. is sufficiently great to result in a finding of oppression.
(6) The court must consider whether there are 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 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.

17. In *Farookh v Germany* [2020] 3143 (Admin) Fordham J characterised the "ultimate determinative question" as follows:

> "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."

18. The Divisional Court provided the following guidance on *Turner* proposition (4) in *Modi v Government of India* [2022] EWHC 2829 (Admin), where Stuart-Smith LJ said:

"In our judgment, to the extent that *Turner* proposition (4) adds anything to (3) and (5), its function is to indicate that in situations where the decision to commit suicide is voluntary, in the sense of being rational and thought-through, a finding of oppression should not be made… In particular, we would deprecate any attempt to introduce concepts of causation as are routinely applied in tort or contract: the fact that (in conventional causational terms) a person's depression would be either a cause or even the dominant cause of a person's decision to commit suicide does not mean or necessarily suggest that the act was not voluntary within the meaning of *Turner* proposition (4)…

… In our judgment, *Turner* proposition (4) should be read in a common-sense, broad-brush way giving full effect to the question whether the act of suicide would be the person's voluntary act. This approach does not demand proof of 'impulse' as that term is used by clinicians [128-9]."

19. In the Fifth Judgment Fordham J repeated what he had said in *Farookh* and added:

"13. One aspect of this involves asking whether suicide would be 'by reason of a mental condition removing the capacity to resist the impulse to commit suicide". *Modi* explains the difficulties with 'impulse' (§125), 'capacity' (§126) and 'voluntary acts' (§127), in the context of what clinicians would mean and recognise. In the present case, the Judge recorded the evidence of Dr Poole that the legal test of resisting the impulse to act is not a clinical one. *Modi* has identified a common sense broad-brush approach (§129), asking whether the decision to commit suicide is 'voluntary, in the sense of being rational and thought-through' (§128); 'the person's voluntary act' (§129). This is notwithstanding that 'many psychiatrists would have difficulty with the notion of 'voluntary acts' (*Modi* §127). Dr Hillier (6.6.24) says that suicidality as a 'rational' or 'capacitous' decision responding to adversity 'is not current thinking within mental health circles, particularly when there is evidence of mental disorder known to predispose to suicidality as part of the psychopathological manifestation of the illness'. The Courts's view in *Turner* (§§43 and 70) and evidently also *Modi* (§140) was that suicide would be a voluntary act.

14. Another aspect involves asking about suicide risk 'whatever steps are taken', where the Court is 'satisfied that appropriate arrangements are in place'. This must include consideration of steps and arrangements in the UK (Stage 1) and for transfer (Stage 2). That makes the encapsulation:

> **The question is whether, on the evidence, whatever steps are taken – and even if the Court is satisfied that appropriate arrangements are in place including 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.**

In the present case, as Dr Hillier points out, [the Respondent's expert witness] Dr Picchioni told the Judge that the risk of suicide in the event of deterioration in the Appellant's mental state 'can potentially be managed but will likely require intensive and potentially restrictive intervention by prison and mental health services in order to successfully manage that risk'. As to the present position in the UK, Dr Hillier has identified appropriate arrangements. Steps and arrangements are described. In *Turner*, there was a 'danger period' which was 'between the dismissal of the appeal and the appellant's removal to the UK' (§14). The requested person was on bail, and recent events included admission to hospital (§17) and to a psychiatric facility (§24). The Court ensured that it had information about what steps could be taken (§10), and was thus satisfied as to appropriate measures (§§39, 72)."

20. Section 103 gives a right of appeal from the decision of the District Judge to the High Court, subject to the High Court granting leave. There is ordinarily a time limit of 14 days from the date on which the Secretary of State informs the requested person of the extradition order.

21. Under section 104, the Court may allow an appeal and must order the person's discharge if one of the following sets of conditions is satisfied:

> "(3) The conditions are that—
>
> (a) the judge ought to have decided a question before him at the extradition hearing differently;
>
> (b) if he had decided the question in the way he ought to have done, he would have been required to order the person's discharge.
>
> (4) The conditions are that—
>
> (a) an issue is raised that was not raised at the extradition hearing or evidence is available that was not available at the extradition hearing;
>
> (b) the issue or evidence would have resulted in the judge deciding a question before him at the extradition hearing differently;
>
> (c) if he had decided the question in that way, he would have been required to order the person's discharge."

22. In addition, a person may apply for leave to appeal against an extradition order, out of time, on human rights grounds under section 108(5). Under subsection (7), leave is to be granted only if (a) the appeal is necessary to avoid real injustice; and (b) the circumstances are exceptional and make it appropriate for the appeal to be heard.

23. In relation to grounds other than infringement of the ECHR, including the ground based on section 91, a person may apply in writing to the High Court to re-open a decision which determines an application for permission to appeal under rule 50.27 of the Criminal Procedure Rules:

"(3) The application must—

(a) specify the decision which the applicant wants the court to reopen; and

(b) give reasons why—

(i) it is necessary for the court to reopen that decision in order to avoid real injustice,

(ii) the circumstances are exceptional and make it appropriate to reopen the decision, and

(iii) there is no alternative effective remedy."

Evidence of transfer arrangements

24. In addition to evidence previously served by the Respondent about arrangements for the Appellant's safety, on 15 July 2024 the Respondent submitted affidavits from Captain Willem Jacobus Van Der Heever, a police officer based with INTERPOL Pretoria in charge of transporting the Appellant from the UK to South Africa and Lieutenant Colonel Dereck Peter Du Plessis, the investigating officer concerned with the Appellant's case.

25. An application was made on 22 July 2024 for permission to rely on that evidence together with an affidavit sworn on that date by Peter Gebuza, an official of the Department of Justice and Correctional Services. The application stated that all of this evidence had been served as and when it became available and had been obtained in response to the Appellant's fresh evidence.

26. Captain Van Der Heever stated that the following measures would be taken to prevent the Appellant from committing suicide during his transfer (the numbering is incorrect in the original):

"5.1 Mr Lomas will be searched and his luggage will be searched when the team of INTERPOL PRETORIA receive him at the airport. He will not be permitted to possess any objects that may pose a serious and obvious danger to himself. He will also walk through metal detectors at the airport.

5.2 The INTERPOL team will consist of 4 members of the South African Police Service. During the flight the INTERPOL members will sit around him in the transfer to South Africa.

5.4 Mr Lomas' medication will be handed over to the accompanying doctor from South Africa and will be retained by the doctor and only the correct doses will be administered to him at the appropriate times.

5.5 Mr Lomas will be continuously monitored by the Interpol team during the flight and at all stages of the transfer from the United Kingdom until he is

handed over to the investigating officer and his team, upon his arrival in South Africa.

5.4 On the Flight Mr Lomas will not be permitted to possess any objects that may pose a serious and obvious danger to himself.

5.5 On arrival in South Africa Mr Lomas will be handed over to the investigation officer Lt Col Derrick Du Plessis who will deal with his safe keeping in South Africa."

27. Lieutenant Colonel Du Plessis stated that on arrival in South Africa the Appellant will be handed over to him and formally arrested. He will be under direct supervision at all times. Lt Col Du Plessis will at all times be accompanied by two other police officers. Upon arrest the Appellant will be taken to the police station at the airport for "formal processing". There he will be searched and will not be permitted to possess any potentially dangerous objects. He will then be taken to Court for his first appearance without being detained in any holding cells. He will then be transported to the Johannesburg Correctional Centre. Up to that point, Lt Col Du Plessis and the other two officers will be present. At the Correctional Centre the Appellant will be handed over to an appropriate official and undertakings made by that department "will be adhered to by them". From the arrest and until the Appellant is booked in at the Correctional Centre, the "accompanying doctor" will be present, will administer any medication at the appropriate times and will "attend to any medical attention he might need". In addition:

"7.1 For any court appearances after the first appearance while Lomas is in custody he will be transported from the Correctional Facility to court and back to the Correctional Facility by at least three members of the South African Police Services from my office.

7.2 Lomas will at all times be under South African Police Services' supervision when he is booked out from the Correctional Facility for court appearances."

28. The affidavit of Mr Gebuza referred back to affidavits sworn by him in the extradition proceedings in 2022. I refer in particular to an affidavit sworn on 8 March 2022 which described the medical facilities available to prisoners at the Johannesburg Correctional Centre. Mr Gebuza stated that within 6 to 12 hours of admission, an initial health and physical risk assessment would be conducted by a nurse to determine urgent health needs. This would include screening of "suicidal ideas/attempts". He referred to the centre's "suicidal inmate management" whereby the Appellant "will be placed in a single cell and an official will be allocated to regularly check the inmate during day and night shifts. The number of checks will depend on the assessment of the suicide risk posed by the inmate." Medication would be issued daily to avoid overdosing and psychiatric services could be accessed.

29. Mr Gebuza's new affidavit added this about the assessment of the Appellant's mental and physical health upon his admission to the Correctional Centre:

"5.1 In addition to the admission process set out in my affidavit dated 22 March 2022 paragraphs 1.9 to 1.12 thereof, Michael Lomas will within 12 hours of his admission to JCC be assessed by a doctor and, if appropriate, be referred on an urgent basis to Chris Hani Baragwanath Hospital for an assessment of his physical and mental health. In those circumstances I would expect him to be assessed at the hospital within 24 hours of his admission at JCC.

5.2 All medical reports/records will be made available to the doctor from the Department of Correctional Services prior to Mr Lomas' arrival at the Correctional Facility in preparation for the assessment."

30. The Respondent also relied on a brief statement dated 19 July 2024 by PC Gorby Singh of the National Extradition Unit ("NEU"), who had provided some information to the Court by email which was considered by Fordham J on 26 March 2024. PC Singh had informed the Court that Mr Lomas would be taken immediately to the hospital following his arrival in South Africa, but he now identified this as a misunderstanding arising from a telephone conversation with Captain Van Heever, with the correct position being as described in the new affidavits. Secondly, PC Singh confirmed that the NEU would not notify Mr Lomas of the date of his removal from the UK in advance (as had happened previously) so as to minimise the risk of him taking his life between the notification and the removal. Instead, the NEU with the South African police officers and doctor who would be accompanying him in transit, would collect Mr Lomas, giving him an opportunity to pack his belongings in their presence before taking him immediately to the airport.

Evidence of the Appellant's medical needs

31. I am told that the Appellant is now 76 years old. Medical evidence from a GP, Dr Mitchell, explains that he has had a number of health problems. Multilateral degenerative disc disease of the cervical spine have caused weakness of his right arm and hand, poor balance, unsteadiness and poor mobility. He had spinal surgery on 6 June 2023 and 2 April 2024. In May 2024 he developed bloody diarrhoea which was initially thought to be due to a flare up of diverticular disease from which he had suffered for much of his life. It has continued and he is awaiting hospital tests for colorectal cancer. He is convalescing from his surgery in a care home.

32. At the extradition hearing the DJ heard evidence from a neuropsychiatrist and a neuropsychologist, Dr Poole, on the Appellant's behalf and from a psychiatrist, Dr Picchioni, on behalf of the Respondent. It was found that the Appellant suffered from a Recurrent Depressive Disorder and was in a likely Moderate episode with an elevated risk of suicide. The DJ concluded that these problems could be sufficiently managed in prison if the Appellant were extradited to South Africa.

33. In 2024 Dr Mitchell reported that the Appellant's mental health had deteriorated significantly and recommended an updated psychiatric assessment.

34. As I have said, Dr Hillier saw the Appellant on 5 June 2024 and stated in a letter of that date that the suicide risk was "extremely high and potentially imminent".

35. In his report dated 6 June 2024 Dr Hillier set out a psychiatric history of depressive problems with some suicidal ideation dating from around 2013. This includes a hospital admission for about one month soon after the extradition hearing. The Appellant was now under the care of the mental health team and taking a range of medications. He described a previous episode of self harm in about 2022. He said that suicide felt like a logical thing to do, that the "knowledge that I have to get on the plane" would precipitate it and that he had thought about methods such as overdose.

36. Dr Hillier summarised his conclusions:

> "7. Mr Lomas presented as suffering from a Severe Depressive Episode without Psychosis in the context of a Recurrent Depressive Illness at the time of my assessment.
>
> 8. Mr Lomas demonstrated an exceptionally high risk of completed suicide at the time of my assessment.
>
> 9. Whilst properly being a matter for the Court, I consider that Mr Lomas' risk factors and vulnerabilities is at a very high risk of being overcome by his suicidal ideation in the near future.
>
> 10. I have made urgent contact with Mr Lomas' NHS mental health team in order that they can also assess and manage his risk of completed suicide."

37. The report explained that the Appellant has a number of particular risk factors for suicide, including his diagnosis of Severe Depressive Episode, gender, age and history of self harm. Stressors were said to be a significant risk factor, and the thought of extradition and imprisonment in South Africa were "considerable stressors" for him. The prognosis was "not ... particularly good … independently of his risk of being extradited":

> "Mr Lomas has a wide range of reasons to be suicidal, if one were to argue that suicidality is a 'rational' or 'capacitous' decision and response to adversity (which is not current thinking within mental health circles, particularly when there is evidence of mental disorder known to predispose to suicidality as part of the psychopathological manifestation of the illness). I am also mindful of recognition that there is limited evidence in research to draw on about the interplay between extradition and mental health issues, which further adds to the difficulties of risk assessment in this challenging area."

38. In answer to the question of whether the Appellant had the capacity to resist suicidal impulses, Dr Hillier said:

> "Whilst the concept of an irresistible impulse may be something that is present for some at the time of carrying out the suicidal act for some people in some circumstances, this conceptualisation appears to neglect the reaching of thresholds and removal of protections that can happen progressively that mean an individual comes to a decision to end their life; the complexity of routes to suicide is reflected in the variety of theoretical models that exist both to attempt

to assess suicide risk and to put into place preventative measures for suicidal people."

39. The report continued:

> "In Mr Lomas' case, in my view the thresholds as demonstrated by the presence of risk factors and the cumulative impact of physical and psychosocial stressors is such that a critical point has been passed in terms of his likelihood of carrying out suicide. In my opinion, and in the context of the presence of a severe mental illness, namely a severe depressive episode, I do not consider it can be said that he has genuine voluntary control over his thoughts and acts as they pertain to suicide, this being a core feature of the mental disorder. I recognise that this is an exquisitely difficult judgement to make from a clinical perspective, and a good proportion of the completed suicides that occur amongst depressed people globally occur when this judgement has been incorrectly made, in retrospect; and it is impossible to know whether an individual would have in fact killed themselves when mental health services do intervene. The question as to whether Mr Lomas can resist the 'suicidal impulse' is ultimately a matter for the Court, but from a clinical perspective Mr Lomas appears to present in the worst mental state that he has done to date, and there are a wide range of reasons for this which are of genuine and imminent clinical concern."

40. As to the likely effect of extradition on the Appellant, Dr Hillier found this "an exceptionally difficult question to answer" but concluded:

> "It is only possible to say that Mr Lomas would continue to present with the same risk factors, just potentially in less comfortable surroundings and with less access to social support which he has in the UK. He would also have interruptions in his physical and mental healthcare provision, and would have a challenging custodial environment to adapt to with unknown consequences; it would appear a reasonable conclusion that such a situation would be detrimental on his mental health, but it is not possible to say with absolute certainty."

41. Dr Hillier saw the Appellant on 1 July 2024 and provided a further letter to the Court dated 3 July 2024. The Appellant complained of continuous symptoms of diverticular disease and of constant pain in his right shoulder and arm. He was "emotionally down" about his physical state and had trouble sleeping. He was taking prescribed psychiatric medication intermittently. He thought about suicide every day. Suicidality came in surges and he did not feel that his family connections or churchgoing were currently protective factors. He said that he did not have access to the means of harming himself but that he would be able to do so. Dr Hillier remained of the view that the Appellant had "a severe depressive episode with chronic suicidality". He said:

> "I remain concerned that Mr Lomas is presenting with a wide range of risk factors for completed suicide, and in addition there are developments in his mental state and circumstances that have further implications from a risk perspective, including that his support from his son appears to be being detrimentally affected

by these proceedings, and results from his physical health investigations have demonstrated disease progression."

And:

"In summary, I considered at the time of my assessment that Mr Lomas' risk of suicide remains extremely high and potentially imminent; I had no reason to consider that he was malingering this in the context of his clinical presentation and previous assessments."

42. In a further letter dated 8 July 2024 Dr Hillier responded to a number of specific questions.

43. To the question *Whether and to what extent the suicide risk arises by reason of extradition or independently of it*, he said that although one could not easily quantify the relative contributions of different factors:

"… the reality of extradition would likely be a critical factor in terms of his risk of attempting and completing suicide being very high, as I think it would abolish any residual resilience that he currently has."

44. To the question *Whether suicide would be a voluntary act; whether appropriate steps have been identified*, he said:

"I struggle to answer this question from a clinical perspective, as I am aware the concepts differ in law. I am aware that under some circumstances decisions made capacitously by patients to refuse treatment which will result in the end of their lives can be regarded as voluntary. I do not consider that the situation whereby Mr Lomas were to decide to take his life could be regarded as a comparable situation, both in terms of circumstances in relation to health, or in the context of his clearly having a co-morbid depressive illness. As noted previously, it is well recognised that suicidal ideation and acts are features of a depressive illness, and Mr Lomas does have a depressive illness. In my view, it would follow that given the complexity of Mr Lomas' physical and mental health risks of completed suicide in the context of a depressive illness, from a clinical perspective extradition would merely serve as a further dynamic factor to contribute to suicidal behaviour."

45. Asked to comment on assurances and safeguards that could be put in place at pre-transfer and transfer stage to reduce the risk of suicide, he stated in a yet further letter to the court dated 17 July 2024 that the most effective way of managing the risk would be continuous 1:1 observation by a qualified and registered mental health nurse. He considered that risk to the Appellant "would not be able to be adequately managed in a prison setting", noting that this "is not a health setting, and will be significantly complicated by his complex physical and mental health problems".

46. Dr Hillier also stated that transfer should be regarded as "a primarily medically-focused transfer" and that the transfer team "should include individuals who are medically trained and able to manage pain, agitation and emergency situations in terms of the administration of medication". He recommended that the Appellant

initially be transferred to a hospital setting where he could be assessed by trained mental health professionals.

47. In the same letter Dr Hillier considered the Respondent's recent assurances. He described Captain Van Der Heever's statement as to how suicide risk will be managed as "quite simplistic" and as assuming "that the only way he could harm himself would be through objects that may pose a 'serious and obvious danger to himself'". He also noted that Lt Col Du Plessis' statement makes no mention of any accompanying medical professional or of any process to consider the Appellant's fitness to appear in Court.

48. At the hearing I was informed that further questions had been put to the Respondent's witnesses. Captain Van Der Heever has now confirmed that the accompanying doctor is a person with training in psychiatric matters, can deal with any matters arising during the transfer and will be with the Appellant until he has been taken to the Correctional Centre, and that the escorting team will be aware of his medical and psychiatric history.

49. The present arrangements for the care of the Appellant are described in a witness statement by Joanna Byles, the Team Leader of the care home where the Appellant has resided since 4 April 2024. The care home staff were not aware of the extradition proceedings until 21 May 2024. Since then, the Appellant has expressed thoughts of suicide. Staff now conduct hourly welfare checks on him. Monitoring could be increased to half hourly but this is not presently thought necessary. He has surrendered his key fob so he cannot leave the home. He has daily visits from the crisis team. The staff hold his medications. His treating psychiatric consultant, Dr Das, does not feel that admission to psychiatric hospital would be appropriate.

50. At the hearing before me, the Respondent also sought permission to rely on further reports by Dr Picchioni dated 23 and 25 July 2024.

51. In the first of those reports, from the information in the papers Dr Picchioni recommended (in particular) that during the "danger period", the risk and the frequency of monitoring should be reviewed. From being informed of an unsuccessful appeal he should be given 24 hour 1:1 observation, reducing to intermittent checks if his condition improves. His room and possessions should be checked for anything enabling self-harm. If he transfers to custody, there should be screening on the day of arrival and there should be a proper handover with a fully psychiatric history. It would be "safest and most effective" for him to be initially admitted to a health care wing. Care home staff and the mental health team should be involved in considering how to inform him of a decision to dismiss his appeal. Consideration should be given to remanding him into custody before then, though on balance the care home may be "a more therapeutic and potentially equally safe setting". Similar risk management strategies as the above should be used at the airport, during the flight and transfer and on his initial reception into prison in South Africa.

52. The second report followed Dr Picchioni being shown the evidence and assurances from the South African authorities, and Dr Hillier's most recent letter to the Court. He recommended that the community mental health team and care home staff continue at least daily reviews, with a low threshold to the implementation of 1:1 monitoring by

an experienced and informed staff member (but not necessarily a mental health nurse). He should be informed of any dismissal of his appeal only on the day of extradition. Upon transfer the escorting team should be informed of his medical history, treatment plans and needs and the accompanying doctor should have psychiatric training sufficient to allow them to deal with issues that may arise.

The Appellant's submissions

53. I received a skeleton argument from David Josse KC and Rebecca Thomas on behalf of the Appellant. They submitted:

(1) The seriousness of the Appellant's psychiatric conditions satisfy the requirement in *Turner* of a substantial risk of suicide in the event of extradition.

(2) Despite the difficulty reported by Dr Hillier of assessing suicide as voluntary or involuntary from a medical perspective, his evidence is valuable by identifying the "wide range of risk factors for completed suicide" and how the effect of those factors is to be distinguished from, for example, a capacitous decision by a patient to refuse life-saving treatment. This is sufficient to satisfy the "common-sense, broad-brush" approach described in *Modi*.

(3) The Respondent (at that time) had not re-instructed Dr Picchioni and so the medical evidence on behalf of the Appellant is unchallenged.

(4) In the letter of 17 July Dr Hillier stated that the Appellant's present care home treatment was not sufficient to manage the acute risk which would arise from extradition, that a prison environment would be equally unsuitable and that the most appropriate setting would be a hospital with 1:1 observation by a mental health nurse.

(5) Fordham J accepted that it would be appropriate for the Appellant to be taken to a medical facility in South Africa (Third Judgment paragraph 29, Fourth Judgment paragraph 20). But it seems from the affidavit of Lt Col Du Plessis that when the Appellant arrives in South Africa, he will be taken to the police station, thence to the Court and thence to the Correctional Centre. Dr Hillier describes a prison setting as greatly increasing the risk of suicide. In the latest evidence on behalf of the Respondent there is no mention of medical assessment, nor of any possibility of bail and there is no information about the accompanying doctor.

(6) In these circumstances it is submitted that the Appellant's extradition would be oppressive, contrary to section 91, and/or would be a breach of his Article 3 rights.

54. Miss Thomas also made oral submissions.

55. First, she made an oral application to re-open the previously determined grounds based on the Appellant's physical health needs. The basis for this was two articles from the South African press. Discovery of these was prompted by the new evidence from Mr Gebuza. A search was made relating to him and this uncovered the two

reports from the News24 website about a case in 2023. A quadriplegic criminal defendant in a South African court had his jail sentence suspended after the court heard evidence from Mr Gebuza to the effect that no prison could accommodate him because he needed 24 hour care and was unable to bathe, brush his teeth, turn when lying down or go to the toilet unaided. In light of this, Miss Thomas submitted that the assurances previously given by the Respondent about the Appellant's care were no longer adequate.

56. Miss Thomas also submitted that the overall picture is changed by the fact that the Appellant will not go straight to a medical facility in South Africa, Fordham J having previously assumed that he would and having indicated that this was appropriate.

57. Turning to the anticipated agenda for this hearing, Miss Thomas then concentrated on the question of whether the Appellant's suicide risk was so great as to make his extradition oppressive or a breach of Article 3. She emphasized the sudden and urgent nature of the concern identified by Dr Mitchell, notwithstanding the previous consideration of mental health issues. She urged me to reject what appeared to be an attempt by the District Judge in his judgment to decide what would happen if his mental state worsened before this had actually happened. There is, she submitted, a real risk of injustice if the post-judgment evidence is not explored.

58. Miss Thomas also emphasized the serious nature of the deterioration, signalled by Dr Hillier's view that the risk is extremely high and potentially imminent.

59. She accepted that the issue of whether suicide would be voluntary is made difficult by the lack of alignment between the *Modi* test and the medical approach to causation of suicide. However, she relied on Dr Hillier's evidence in his letter of 8 July that "suicidal ideation and acts are features of a depressive illness" and that "from a clinical perspective extradition would merely serve as a further dynamic factor to contribute to suicidal behaviour". The further reference to extradition being apt to "abolish any residual resilience that he currently has" showed that this was something happening to him, rather than something that he was doing of his own volition.

60. In respect of the inadequacy of the care home risk management at stage 1, she reminded me that in *Farookh* Fordham J explained that it might not be enough for authorities to do their duty and that the real question concerned the outcome.

61. In respect of stage 2, Miss Thomas noted that the Respondent's assurances did not match Dr Hillier's opinion that the accompanying doctor should be a consultant psychiatrist, and did not necessarily correspond with Dr Picchioni's advice either. Overall there was, she submitted, a significant enhancement of the risk which itself would amount to a breach of Article 3.

62. In respect of stage 3, Miss Thomas submitted again that it was not logically possible for the DJ to rule that assurances given by the Respondent would sufficiently protect the Appellant in the event of a future deterioration of his health. Instead, *Turner* proposition (1) means that the Court must assess the facts as they are now.

63. The facts, she submitted, have moved on. New evidence relevant to stage 3 includes the press reporting of Mr Gebuza telling a court that the prisons in South Africa

cannot provide 24 hour care. Meanwhile the evidence before the District Judge about conditions in South Africa must be seen against the current facts. That included an affidavit sworn on 10 October 2022 by a Dr Mustafa, a Clinical Director at the teaching hospital near the Correctional Centre. He stated that prisoners who required in-patient psychiatric care would be kept in the prison overnight but could be brought to the hospital each day for treatment. Miss Thomas submitted that this could no longer be seen as an adequate proposal, in light of Dr Hillier's evidence of a very high risk of suicide which would increase sharply in the event of extradition. Dr Mitchell indeed rejected the efficacy of that suggestion in his report of 4 December 2023.

64. In short, Miss Thomas submitted that on the current evidence the Respondent's assurances fall well short of what psychiatrists on both sides have considered to be necessary, and that the risk of suicide upon extradition is so high that the Appellant should be discharged.

The Respondent's submissions

65. Mr Payter made written and oral submissions on behalf of the Respondent. He reminded me that the test under rule 50.27 and section 108(5) for re-opening an appeal, that it be necessary to avoid a real injustice and that the circumstances are exceptional, is a demanding one. His overall submission was that that test could not be satisfied where the DJ has already heard expert evidence on the mental health and suicide issues and reached a determination, the deterioration in the Appellant's situation is relatively limited, the possibility of such deterioration was recognised by the DJ and the Respondent has given assurances of sufficient mental health treatment and protective arrangements.

66. Mr Payter reminded me that Fordham J envisaged the focus at this hearing being on stages 1 and 2, and also of the case of *Polish Judicial Authorities v Wolkowicz* [2013] EWHC 102 (Admin) at paragraph 10a where the Court pointed out that in a domestic case a person does not escape a sentence of imprisonment because of a high risk of suicide; rather the court relies on the executive to implement measures to care for the person.

67. Mr Payter drew a contrast between the present case and *Farookh* where a finding of oppression was made. The requested person there suffered from a severe form of PTSD, anxiety and depression and had made a number of recent, genuine and concerted suicide attempts. It was found highly probable that he would succeed in taking his life in the event of extradition and his condition removed the capacity to resist the suicidal impulse.

68. He also compared this case with another successful appeal, *Fletcher v India* [2021] EWHC 610 (Admin). Although Chamberlain J there said at paragraph 39 that "in almost every case, proper preventive measures will reduce the risk of completed suicide below the high threshold required for oppression", and cases where oppression has been found involved recent, genuine suicide attempts, that was only one factor (paragraph 41(a)). The individual's personality disorder and associated impulsivity meant that any suicide attempt would not be voluntary (paragraph 41(c)). The critical issue was said to be the preventative measures in India and in that case, the assurances

were not detailed enough about how the appellant would be supervised (paragraph 41(e)).

69. In *Modi*, by contrast, the Court concluded that there was suitable medical provision and an appropriate plan in place for the requested person's management and care. The Court at paragraph 138 rejected the suggestion he would commit suicide whatever steps were taken given his depression was not at the most severe end, he had displayed no psychotic symptoms, he had not attempted suicide or self-harm and the steps India had taken to make the accommodation safe and to ensure constant monitoring. The Court also concluded at paragraph 140 that suicide would be a voluntary, rational, thought-through act taking into account that the requested person had on multiple occasions contemplated suicide at some point in the future. Those features, Mr Payter submitted, make that case similar to this one.

70. Mr Payter submitted that at worst, the Appellant's depression has increased from moderate, as the DJ found, to a severe depressive episode in the context of a recurrent depressive disorder, and the risk of suicide has increased from "high" to "very high", but that increase was foreseen by the expert witnesses at the hearing (see paragraph 73.iv of the judgment quoted above).

71. On the evidence, he submitted, appropriate measures are already being taken at stage 1. In respect of stage 2 the Court has been informed that the NCA will not notify the Appellant of the surrender date so there is no heightened "danger period", he will be accompanied by a medical doctor all stages of the transfer and he will be searched and accompanied by officers at all times as set out above.

72. In respect of stage 3, Mr Gebuza has given the assurances which are summarised at paragraphs 28-29 above. These were already reflected in the findings in paragraph 73.iii of the DJ's judgment, quoted above.

73. Those assurances, Mr Payter submitted, show that the DJ reached the right conclusion, i.e. that even if there is otherwise a high risk of a completed suicide, it is sufficiently mitigated by the protective steps that will be taken. It also does not appear that Dr Hillier has been asked to review those steps and therefore there is no proper evidential basis for concluding that the steps will be insufficient.

74. As to the risk of suicide, Mr Payter also pointed to the other health issues on which the Appellant has relied in these proceedings – his age, poor health, frailty, inability to walk all but short distances with a Zimmer frame, the use of only one arm and incapability to provide for his own basic daily care needs – and submits that it is not clear how he would achieve it despite steps being taken to prevent him doing so. It is also notable that the care home staff had not thought it necessary to take steps such as preventing the Appellant from having unimpeded access to his medication in a drawer in his room until they became aware of Dr Hillier's assessment. The Appellant has not needed mandatory admission to a hospital at any point during these proceedings.

75. Mr Payter further submitted that it is not reasonably arguable that suicide would be an involuntary act in the sense of being irrational and not thought-through. Dr Hillier's evidence on the point is at best equivocal. The Appellant is not psychotic and no question has been raised about his capacity in any other area of his life. The evidence

shows that he has made considered plans to end his life over the course of more than two years of extradition proceedings and in response to specific developments in those proceedings. It also shows that he has never yet acted on those plans despite extradition being ordered and several appeal applications being dismissed.

76. Finally Mr Payter reminded me of the significant public interest in the prosecution of the offences of corruption of public officials, potentially carrying a long sentence, of which the Appellant is accused.

Discussion

77. Neither party objected to my seeing any of the late evidence to which I have referred, though Mr Payter submitted that I should ultimately refuse to admit the late evidence for the Appellant on the ground that if it had been adduced at first instance, it would not have would have resulted in the DJ deciding a question before him at the extradition hearing differently.

78. I am not persuaded that there is any ground for re-opening the grounds of appeal based on the Appellant's physical health needs, and his oral application to that effect must be dismissed.

79. I do not read any of Fordham J's decisions as turning on the suggestion that the Appellant would be taken directly to hospital in South Africa. It is now clear from Mr Gebuza's evidence that the Appellant will be assessed within 12 hours of his arrival in the Correctional Centre and can be referred to hospital urgently if that proves necessary. Bearing in mind that he is not presently in need of in-patient care but is convalescing in a care home, there is no reason to conclude that he will need hospital care immediately on arriving in South Africa.

80. Nor should the case be re-opened because of the press material relating to a quadriplegic patient. The fact that, on Mr Gebuza's evidence, the South African prison system cannot care for that patient provides no basis for concluding that the Appellant will not receive the care identified in the Respondent's assurances.

81. Turning to the core of the applications before me, this is one of those difficult and disturbing cases where, on the evidence, extradition carries a risk that the requested person will commit suicide. *Turner* proposition (4) explains that it is not sufficient for the requested person to prove that there is such a risk, even a substantial risk. The risk, evaluated in the light of whatever steps will be taken to mitigate it, must be such as to make extradition oppressive (or to infringe Article 3). Applying *Modi*, oppression will not be found where the decision to commit suicide is voluntary in the sense of being rational and thought-through.

82. I accept Mr Payter's submission that this application would fall at that hurdle, even if it could surmount any of the other hurdles.

83. The key passages from Dr Hillier's evidence on this issue are quoted at paragraphs 39, 43 and 44 above. In my judgment the clinical picture as described by Dr Hillier is not one of a patient who is or will be unable to resist suicidal urges. Instead he states,

no doubt correctly, that the suicidal urges are a product of the Appellant's depressive illness. They are therefore a disordered reaction to his situation, as opposed to a rational reaction such as one might see in a terminal patient who decides that it would be better to end their life.

84. That assessment must be considered in the context of the known facts. The Appellant has spent a long time anticipating extradition and, already suffering from a long-established depressive condition as well as debilitating physical health problems, predicts that extradition will be the last straw. The exchanges between the Appellant and Dr Hillier show that the anticipated suicide has been planned, with thought having been given to the method by which it may be carried out.

85. It is also significant that there has been no previous suicide attempt during the extradition proceedings and that precautions against such a risk were not thought necessary during the Appellant's first weeks in the care home. Those facts lead me to conclude that the Appellant has a significant degree of self-control, despite his illness causing him to experience suicidal thoughts.

86. Applying the "common-sense, broad-brush" approach of *Modi*, I conclude that if the Appellant does commit or attempt to commit suicide, that act will be "voluntary" in the sense of being rational or thought-through, even though the suicidal urges may reasonably be regarded as a symptom of his illness.

87. None of this analysis minimises the Appellant's medical condition. The *Modi* approach, which no doubt recognises the strong public policy imperative of the UK honouring its extradition obligations, requires Courts to make potentially harsh distinctions between cases which may not fit comfortably with psychiatric assessments of individuals' conditions. Dr Hillier, in his careful, clear and balanced evidence, explained some of the difficulties of ascribing contributory roles to different factors in suicidal behaviour. I do not question his opinion that suicide is a recognisable feature of depressive illnesses of the kind that the Appellant has. The problem is that a connection between a requested person's illness and the risk of suicide does not, by itself, satisfy the legal test.

88. Turning back to *Turner* proposition (3), I also consider that whilst the evidence shows a potentially high suicide risk, the size of the risk is substantially diminished when consideration is given to "whatever steps are taken".

89. It is necessary to consider all the evidence. Dr Hillier was asked to comment on the affidavits of Captain Van Der Heever and Lieutenant Colonel Du Plessis but has not commented on the wider material which was before DJ Sternberg.

90. The Respondent has said that the Appellant will not learn that his extradition is confirmed until the day when it is to happen, whereupon he will immediately be accompanied by the escorting team. There should therefore be no "danger period" at stage 1 between notification of the removal date and time and removal.

91. So far as the transfer process is concerned, it is now quite clear that the Interpol team on the aircraft will be accompanied by a doctor who will have psychiatric training and who is considered able to deal with any issues that may arise. I do not accept that the

risks at stage 2 will rise to the point of oppression if that doctor is not a consultant psychiatrist, and Dr Hillier's evidence does not explain what practical difference that would make.

92. More generally, whilst it may be impossible to eliminate all risk, it is very hard to see how the Appellant, a frail elderly man, would succeed in taking his life after being searched for dangerous objects and when surrounded by the escorting team.

93. Although it was anticipated that the focus of this hearing would be on stages 1 and 2, there was also no shortage of evidence, both before the DJ and before me, about stage 3 i.e. the arrangements in the Correctional Centre. The evidence of Mr Gebuza confirms that the prison system in South Africa has a policy and practical arrangements to address suicide risks. Those involve the assessment of risk, modifications to cell accommodation and the provision of monitoring at the frequency which is judged necessary. There is also extensive provision for psychiatric support, which prisoners can access at the nearby large teaching hospital.

94. I have noted the evidence that, rather than providing in-patient care, prisoners are liable to be held in the Correctional Centre overnight and taken to hospital each day. I accept that that is liable to provide a less satisfactory standard of care than an in-patient admission. But I am not satisfied that this carries the risks in the present case to a level which is oppressive or contrary to Article 3. Even with the deterioration which is reported in the Appellant's psychiatric condition, he is not presently in need of in-patient care.

95. Having considered all the evidence, I conclude that even if I am wrong in regarding any potential suicide as "voluntary" in the *Modi* sense, appropriate arrangements are in place so that the South African authorities can cope properly with the Appellant's mental condition and risk of suicide.

96. For either or both of those reasons, I therefore conclude that the risk of a completed suicide is not sufficiently great to result in a finding of oppression or a breach of Article 3.

97. In my judgment it is therefore not arguable that the DJ was wrong to reach that same conclusion, with or without regard to the post-hearing evidence. The new evidence on which the Appellant relies would not have resulted in the DJ deciding a question before him at the extradition hearing differently.

98. In relation to the human rights appeal under section 108(5), the appeal is therefore not necessary to avoid real injustice, and nor are the circumstances so exceptional as to make it appropriate for the appeal to be heard.

99. In relation to the application to re-open the appeal under section 91, it is not necessary for the court to reopen the appeal in order to avoid real injustice, and nor are the circumstances so exceptional as to make it appropriate to reopen the decision.

100. The Appellant's applications are therefore dismissed.