Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: HU/17314/2018

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On 8 December 2020	**On 17 December 2020**

Before

UPPER TRIBUNAL JUDGE GLEESON

Between

M M N (ZIMBABWE)
[ANONYMITY ORDER MADE]

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the appellant: Mr Mikhael Puar, Counsel instructed by Henry Hyams Solicitors
For the respondent: Ms Rhona Petterson, Senior Home Office Presenting Officer

DECISION AND REASONS

Anonymity order

Pursuant to Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/269) The Tribunal has ORDERED that no one shall publish or reveal the name or address of M M N who is the subject of these proceedings or publish or reveal any information which would be likely to lead to the identification of him or of any member of his family in connection with these proceedings.

Any failure to comply with this direction could give rise to contempt of court proceedings.

Decision and reasons

1. The appellant appeals with permission against the decision of the First-tier Tribunal dismissing the appellant's appeal against the respondent's decision on 14 August 2018 to make a deportation order and to refuse her human rights claim. The appellant is a citizen of Zimbabwe.

2. The appellant is a foreign criminal:

Background

3. The appellant's undisputed immigration history is as follows. She is a 68 year old woman, who arrived in the United Kingdom in February 1999 with a visit visa, which was valid until August 1999. She then switched to a student visa, which was granted to 30 January 2002.

4. In 2004, the appellant was diagnosed as HIV positive and in August 2004, she began treatment. Unfortunately, not many of the available drugs are suitable for her. She has renal problems and some drug resistance. Her condition is stable and she is monitored twice a year. Her daughter, with whom she is living, retrained as a renal nurse in order to be able to help care for her mother. In the United Kingdom, the appellant has lived in a joint household with her daughter, her son, and her grandchildren. She has another married daughter in Zimbabwe, but that seems to be a difficult relationship: the daughter's husband disapproves of the appellant because she is HIV positive and is hostile to her.

5. Following the expiry of her student leave in 2002, the appellant remained in the United Kingdom without leave. In August 2008 she applied for leave to remain on human rights grounds which was granted, and she had leave to remain outside the Rules and/or discretionary leave until 26 September 2016. From 2009 to 2014, the appellant worked as the manager of a residential home a position with a high degree of trust, as the residents were vulnerable people.

6. On 22 October 2015, the appellant was arrested on suspicion of fraud. She had been manager of a residential home and had stolen that money from a 58 year old man who was unable to manage his own affairs. It was a significant and serious breach of trust, over a substantial period of time. The appellant has never acknowledged that she was guilty. The appellant was convicted, and sentenced to 15 months' imprisonment and a confiscation order of £16551, or 8 months' additional imprisonment if it were not paid. She has served both sentences, as she did not pay the confiscation order monies.

7. The appellant has not reoffended. While in the United Kingdom, the appellant has contributed to the community as much as she can: she produced glowing letters of support and character references from the army, from the prison where she served her sentence, the East Greenwich Foodbank where she volunteers, and from church members.

8. The appellant challenges her deportation with reference to Article 3 ECHR and her medical condition. She has no home in Zimbabwe now and there were difficulties between her and her daughter living in Zimbabwe, because her Zimbabwean son in law was hostile to her following her diagnosis as HIV positive and the stigma of that particularly disease. The appellant's case was that she could not expect to live with her Zimbabwe-resident daughter for that reason.

9. The appellant produced medical evidence, including a report dated 25 November 2019 from Dr Alan Tang FRCP, DFFP, Dip GUM, a Consultant Physician in Genitourinary medicine, who has been treating her since 2004 for HIV. Dr Tang said that the appellant is currently stable on Triumeq, a single combined medication which she takes once daily. Triumeq is a combination of Dolutegravir 50mg, Abacavir 600mg and Lamivudine 300mg. The appellant has twice yearly blood tests to check for side effects and drug resistance. It is not in dispute that this particular combination drug is unavailable in Zimbabwe, particularly Dolutegravir, which was the subject of an Information Request by the respondent.

10. The appellant produced evidence that sending money to Zimbabwe was not easy. The economy was in a poor state, with United States dollars no longer being accepted. Everything had to be paid for with cash, and people had to collect money sent from abroad at a bank, attending personally to do so. Banks made deductions before passing on money from abroad.

First-tier Tribunal decision

11. The appellant's appeal was decided in the First-tier Tribunal in March 2019, before the Supreme Court decided *AM (Zimbabwe) v Secretary of State for the Home Department* [2020] UKSC 17 in April 2020. At [43] the judge gave himself what was then a proper self-direction on the Court of Appeal decision in the *AM* case, which has since been specifically disapproved by the Supreme Court.

12. The judge accepted the expertise of Dr Tang and did not suggest that his report was unreliable. At [39], the judge set out passages from Dr Tang's report. At [45], the judge said this:

> "45. I am satisfied that the appellant's condition would deteriorate if she cannot access Triunuraq [which seems to be a typographical error for Triumeq). Dr Tang does not define 'rapidly'. It has not been established that she would rapidly deteriorate to the extent that she would be 'exposed to a serious, rapid and irreversible decline in his/her state of health resulting in intense suffering or to a significant reduction in life expectancy'. It is by no means clear that if she were to suffer a decline in her health, then that would be 'irreversible'. The doctors have managed to find a cocktail of drugs that works for her and it may be that other drugs would be available that have the same effect, or could reverse the decline. It has not been shown that there would be a likely decline in her life expectancy as a result."

13. The judge also did not find that there was family life between the appellant and her son and/or her daughter. She was not financially dependent, as she had a State

pension, and she had been able to work until her arrest in 2015. The judge found as a fact that the appellant's daughter in Zimbabwe would accommodate and care for her. There were financial difficulties in Zimbabwe, 'but money does get through' and the appellant had her pension.

14. The First-tier Judge dismissed the appeal. The appellant appealed to the Upper Tribunal.

Permission to appeal

15. Upper Tribunal Judge Perkins granted permission by reference to the Supreme Court decision in *AM (Zimbabwe).* He was also concerned that the First-tier Judge failed to deal with evidence from the appellant's United Kingdom-based family that they would be unable to send money to support her in Zimbabwe, 'because the banking system is failing, so that people cannot obtain cash'. Permission was granted on all grounds.

Rule 24 Reply

16. There was no Rule 24 reply from the respondent.

17. That is the basis on which this appeal came before the Upper Tribunal.

Upper Tribunal hearing

18. I heard submissions from Mr Puar for the appellant and Ms Petterson for the respondent. Ms Petterson acknowledged that in the light of *AM (Zimbabwe),* the First-tier Judge's decision could not stand. For the reasons I now give, I indicated at the hearing that I would be setting aside the decision and remaking it by allowing the appeal.

Dr Tang's report

19. I begin by considering Dr Tang's evidence. The appellant presented with pancytopaenia (very low levels of red blood cells, white blood cells and platelets) in 2004. She tested HIV positive. Her CD4 count was 9/mm^3 and her viral load was 114076. Initial treatment got the viral load down to about 5000 copies by the end of 2004, but the appellant was tested for drug resistance and found to have two HIV mutations and to be resistant to four of the usual drugs: nevirapine, delavirdine, efavirenz and didanosine.

20. In February 2005, she was changed to Combivir (atanazavir and ritonavir) and her viral load dropped to 50, with her CD4 count rising to 140. In May 2005, she needed another change of drugs. Between July 2005 and July 2010, she was treated successfully and her CD4 count rose to 840. However, with persistent jaundice, the appellant's regime was changed again: kivexa, darunavir, and ritonavir. This was the regime the respondent asked about in her Information Request.

21. Following further problems, the regime was changed again in September 2016, and in October 2017, the appellant was placed on Triumeq. In March 2019, another mutation was identified, giving her low level resistance to etravirine and rilpivirine.

22. Since December 2017, the appellant's viral load has been less than 20 copies and her CD4 count between 520 and 590. Dr Tang considers that the appellant will need to stay on Triumeq indefinitely, given how low her CD4 count was on presentation in 2004 and the evidence that Triumeq will not cure the infection.

23. Dr Tang's report noted that the appellant's HIV treatment options were restricted by her impaired renal function. He concluded that:

> "The effect of incorrectly taking or stopping the medication would cause *a rapid drop in the CD4 count and a rapid rebound in the viral load, which if prolonged, will cause HIV related symptoms, development of AIDS related illnesses, and eventually death*.
>
> This patient attends for outpatient follow up every 6 months and relied on the service for repeat prescriptions of the snit-HIV [sic] drugs, and also blood test monitoring every 6 months, to check on side effects, CD4 count and viral load, in line with British HIV Association Guidelines. *If she did not have access to medical treatment then there will be rapid decline in the CD4 count and progression of AIDS and death.*
>
> The prognosis is good if the drugs continue to be taken and continue to control the viral load and keep CD4 count within the normal range, and without toxic side effects which would damage other organs. *The prognosis will be disastrous if treatment stopped, for the reasons already given above. …*" [*Emphasis added*]

AM (Zimbabwe)

24. On 29 April 2020, the Supreme Court gave the following guidance on the approach now to be adopted following the decision of the European Court of Human Rights in *Paposhvili*. The most important passage is at [22]-[23] in the opinion of Lord Wilson JSC,(with whom Lady Hale JSC, Lady Black JSC, Lady Arden JSC and Lord Kitchin JSC agreed:

> "22. Following a careful analysis of the decision in the D case and of its own decision in the *N* case, the Grand Chamber in the *Paposhvili* case expressed the view in para 182 that the approach hitherto adopted should be "clarified". The Convention is a living instrument and when, however appropriately, the ECtHR charts its growth, it may generate confusion for it to claim to be providing only clarification. The court proceeded as follows:
>
> > "183. The Court considers that the 'other very exceptional cases' within the meaning of the judgment in *N v The United Kingdom* (para 43) which may raise an issue under article 3 should be understood to refer to situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy. The Court

> points out that these situations correspond to a high threshold for the application of article 3 of the Convention in cases concerning the removal of aliens suffering from serious illness."

… So the Grand Chamber was thereby explaining that, in cases of resistance to return by reference to ill-health, article 3 might extend to a situation other than that exemplified by the *D* case, cited in para 14 above, in which there was an imminent risk of death in the returning state.

23. Its new focus on the existence and accessibility of appropriate treatment in the receiving state led the Grand Chamber in the *Paposhvili* case to make significant pronouncements about the procedural requirements of article 3 in that regard. It held

> (a) in para 186 that it was for applicants to adduce before the returning state evidence "capable of demonstrating that there are substantial grounds for believing" that, if removed, they would be exposed to a real risk of subjection to treatment contrary to article 3;
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> (b) in para 187 that, where such evidence was adduced in support of an application under article 3, it was for the returning state to "dispel any doubts raised by it"; to subject the alleged risk to close scrutiny; and to address reports of reputable organisations about treatment in the receiving state;
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> (c) in para 189 that the returning state had to "verify on a case-by-case basis" whether the care generally available in the receiving state was in practice sufficient to prevent the applicant's exposure to treatment contrary to article 3;
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> (d) in para 190 that the returning state also had to consider the accessibility of the treatment to the particular applicant, including by reference to its cost if any, to the existence of a family network and to its geographical location; and
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> (e) in para 191 that if, following examination of the relevant information, serious doubts continued to surround the impact of removal, the returning state had to obtain an individual assurance from the receiving state that appropriate treatment would be available and accessible to the applicant.

These procedural obligations on returning states, at first sight very onerous, will require study in paras 32 and 33 below."

25. At [32], Lord Wilson confirmed the Supreme Court's understanding that *Paposhvili* was more than 'mere clarification of what the [European Court of Human Rights] had previously said'. In effect, there would now be a shifting burden of proof. It was for the appellant to adduce evidence 'capable of demonstrating that there are substantial grounds for believing' that there is a risk on return of an Article 3 ECHR breach. That is not an undemanding threshold: the requirement is for the appellant to raise a prima facie case of potential infringement, which if not challenged or countered, would establish that infringement.

26. At [33], the guidance in Lord Wilson's judgment concludes:

> "33. In the event that the applicant presents evidence to the standard addressed above, the returning state can seek to challenge or counter it in the manner helpfully outlined in the judgment in the *Paposhvili* case at paras 187 to 191 and summarised at para 23(b) to (e) above. The premise behind the guidance, surely reasonable, is that, while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state. What will most surprise the first-time reader of the Grand Chamber's judgment is the reference in para 187 to the suggested obligation on the returning state to dispel "any" doubts raised by the applicant's evidence. But, when the reader reaches para 191 and notes the reference, in precisely the same context, to "serious doubts", he will realise that "any" doubts in para 187 means any serious doubts. For proof, or in this case disproof, beyond all doubt is a concept rightly unknown to the Convention."

27. At [34], Lord Wilson recorded that neither party had actively invited the Court to refuse to follow *Paposhvili*:

> "[34]. …Our refusal to follow a decision of the ECtHR, particularly of its Grand Chamber, is no longer regarded as, in effect, always inappropriate. But it remains, for well-rehearsed reasons, inappropriate save in highly unusual circumstances such as were considered in *R (Hallam) and R (Nealon) v Secretary of State for Justice (JUSTICE intervening)* [2019] UKSC 2, [2020] AC 279. In any event, however, there is no question of our refusing to follow the decision in the *Paposhvili* case. For it was 15 years ago, in the *N* case cited at para 2 above, that the House of Lords expressed concern that the restriction of article 3 to early death only when in prospect in the returning state appeared illogical: see para 17 above. In the light of the decision in the *Paposhvili* case, it is from the decision of the House of Lords in the *N* case that we should today depart."

28. I proceed, therefore, to apply that approach to the appellant's case.

Analysis

29. The first question is whether the appellant's evidence, if not countered, would establish a breach of Article 3 ECHR. The passages cited from Dr Tang's report, taken with the evidence about the lack of the particular combination therapy which has worked for the appellant for the last three years, are plainly sufficient to meet the Article 3 ECHR standard. Dr Tang's clear evidence was that if returned to a country where that treatment was unavailable, the appellant would suffer a rapid decline in CD4 count, an equally rapid rise in her viral load, and if the absence of treatment persisted, death.

30. The next question is whether the Secretary of State has done enough to counter that evidence, and to dispel any serious doubts raised by the appellant's case, subjecting the alleged risk to close scrutiny, addressing reports of reputable organisations about treatment in the receiving state, and verifying, on a case by case basis, whether the care generally available in Zimbabwe was in practice sufficient to prevent the appellant's exposure to treatment contrary to Article 3 ECHR, and the accessibility of the treatment to this appellant, including cost, family network, and geographical location.

31. In default of satisfactory evidence to that effect, the returning state is required to obtain an individual assurance of appropriate, accessible treatment for the particular appellant.

32. The Secretary of State's evidence in this appeal was not prepared by reference to the Supreme Court guidance. She produced her CPIN of April 2019 on Medical and Healthcare Issues, and Responses to two information requests, one dated 28 December 2018 about support for lone women, and one dated 3 February 2020 concerning HIV/AIDS.

33. The December 2018 Response, dealing with single women, says there is no publicly available information on the support for single women in Zimbabwe from UN RefWorld, US State Department, UNHCR, or the Canadian IRB. The information which the Response does contain, which originates from Zimbabwean documents, is mainly about banking facilities and loans for single women, and the constitutional status of women. It does not assist me with the issue in this appeal.

34. In the April 2019 CPIN on medical and healthcare issues, the respondent acknowledged assistance from MedCOI in the preparation of the report:

> "MedCOI is an Asylum and Migration Integration Fund financed project to obtain medical country of origin information. The project allows 11 European Union member states plus Denmark, Norway and Switzerland to make use of the services of the 'MedCOI' team in the Netherlands and Belgium. The MedCOI team makes enquiries with qualified doctors and other experts working in countries of origin. The information obtained is reviewed by the MedCOI project team before it is forwarded to the UK or other national COI teams. Previous MedCOI responses are stored on its database which participating states are able to access."

35. At section 8, the CPIN records that there are now a million people in Zimbabwe on HIV treatment, although 1.3 million are said to be living with HIV in 2016 and 2017. Deaths from AIDS-related illnesses fell from 61000 in 2013 to 22000 in 2017. A 'treat all' approach is taken. There is a list at 8.2.4 of available HIV anti-retroviral drugs, including most of the drugs which the appellant has taken, but no longer takes, either because of side effects or drug resistance. However, at 8.2.5, the CPIN says this:

> "8.2.5MedCOI reported that the following ARV drugs, used in the treatment of HIV/AIDS, are not available in Zimbabwe:-
>
> - Cobicistat
> - Rezolta
> - elvitegravir
> - Stribild
> - dolutegravir
> - triumeq."

36. That is a clear statement that the treatment on which the appellant is currently stable, is not available in Zimbabwe.

37. The February 2020 HIV/AIDS Response, again based on MedCOI research says that darunavir, emtricitabine and ritonavir are available in Zimbabwe, along with various moisturisers needed by people with HIV. There is no mention of the components of Triumeq (Dolutegravir, Abacavir and Lamivudine). A footnote from MedCOI, who prepared the information response, says that the information provided is expressly limited to the availability of medical treatment, not its accessibility.

38. It follows that the respondent has failed to establish that the care generally available in the receiving state is in practice sufficient to prevent a rapid deterioration in the appellant's health, and if not corrected, her death. There is no evidence of the accessibility of the treatment she needs, because it is unavailable in Zimbabwe. The respondent has not sought an individual assurance from Zimbabwe that appropriate treatment would be available and accessible to this appellant, in context, Triumeq and six monthly monitoring for side effects and/or drug resistance.

39. On that basis, the appellant's Article 3 case is made out and, applying section 33(2) of the 2007 Act, Exception 1 applies to her. There is no obligation on the Secretary of State to make a deportation order.

40. I have reviewed the appellant's statements and the medical evidence. While the appellant's deportation is in the public interest, and the offence she committed was a serious breach of trust, on the facts of this appeal it is outweighed by the health risk to her if she is returned to Zimbabwe. I am satisfied that it would be a breach of Article 3 ECHR to return this appellant to Zimbabwe, where she is likely to suffer a serious, rapid and irreversible decline in her state of health, and a significant reduction in her life expectancy.

41. The appeal is therefore allowed.

DECISION

42. For the foregoing reasons, my decision is as follows:
The making of the previous decision involved the making of an error on a point of law.
I set aside the previous decision. I remake the decision by allowing the appeal.

Signed *Judith AJC Gleeson* Date: 8 December 2020
Upper Tribunal Judge Gleeson