Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: HU/08899/2017**

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On the 21st September 2021	**On the 19th October 2021**

Before

UPPER TRIBUNAL JUDGE GLEESON

Between

F M (ZIMBABWE)
[ANONYMITY ORDER MADE]

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the appellant: Ms Sandra Akinbolu of Counsel, instructed by GDS Immigration Law
For the respondent: Mr Toby Lindsay, a 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 F M 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 against the decision of the First-tier Tribunal on 28 March 2019 dismissing his appeal against the respondent's decision on 8 August 2017 to make a deportation order and to refuse his asylum, humanitarian protection and human rights claims.

2. The appellant is a citizen of Zimbabwe born in February 1995, now 26 years old. His challenge to the deportation decision is on human rights grounds, with reference to Articles 3 and 8 ECHR.

3. **Mode of hearing.** The hearing today took place face to face. The appellant gave oral evidence, as did his father. There was no other oral evidence.

4. **Vulnerable appellant.** The appellant has paranoid schizophrenia. He has auditory hallucinations (he hears voices criticising him). His sleep pattern is often disturbed and he needs regular antipsychotic medication to manage his symptoms. He is a vulnerable person and is entitled to be treated appropriately, in accordance with the Joint Presidential Guidance No 2 of 2010: Child, Vulnerable Adult and Sensitive Appellant Guidance.

5. Ms Akinbolu accepted that the medical evidence was that the appellant was fit to testify and asked for no particular adjustments to be made during the hearing. I asked the appellant during his evidence whether he felt all right and he said he was fine. It was not suggested that the appellant was in any difficulty during the questions asked by Ms Akinbolu, Mr Lindsay, or me.

Background

6. The appellant entered the United Kingdom in 2003, age 8, as his father's dependant, along with his mother. The appellant has been lawfully in the United Kingdom throughout, until the deportation order, with indefinite leave to remain.

7. The appellant has a sister, who was born here in 2004 and is now 17 years old. His parents and sister, with whom he still lives, are all British citizens by birth or naturalisation. His father is a quantity surveyor by profession, and his mother is a nurse.

8. The appellant's maternal grandparents live in Zimbabwe, and are now aged 70 and 66 respectively. They are supported financially and emotionally by the appellant's parents in the United Kingdom. The appellant and his family are in regular weekly contact with them by WhatsApp.

9. The appellant has lived in one household with his family members for most of his life, save for a fortnight or so, when he stayed with his grandparents in Zimbabwe in 2011 or 2012 to take some examinations, a few months study in Malaysia in 2013, when his illness became apparent, and during his imprisonment and subsequent licence period.

10. The appellant and his family lived together in the United Arab Emirates and Qatar between 2007 and 2013. In 2013, the family returned to the United Kingdom, and the appellant returned from his studies in Malaysia to join them, because he was so unwell. He was 18 years old and had been using cannabis, including skunk, for about 5 years. The appellant had difficulty in complying with a medication regime: he had attempted both self-medication and self-harm.

11. On 5 May 2015, the appellant was convicted of two counts of battery, fined, and paid costs and a victim surcharge. The respondent and the sentencing judge disregarded that conviction when considering the arson which was the index offence for his imprisonment and the deportation order.

12. Also in 2015, having not taken his medication for six or seven weeks, the appellant had an argument with his father at home, and set fire to the family flat while his father was in it. He used a lighter, but no accelerant. The appellant left the flat, but then went back, and was rescued with his father. He was sectioned under the Mental Health Act. Doctors concluded that his behaviour was influenced by his psychotic symptoms and the use of cannabis at the time, and that he was unaware of the nature and consequences of his actions. However, in March 2016 he was convicted of reckless arson and sentenced to 4 years' imprisonment. His family members visited him in prison every week during his sentence.

13. On his release in November 2018, the appellant lived for a time in supervised Probation Service accommodation, with regular visits from his parents and sister. He had completed various courses in prison and is studying for a quantity surveying qualification (his father's profession) online. The appellant told Dr Sen that he had been drink and 'smoke' (cannabis) free for two years and was more responsible now.

First-tier Tribunal decision

14. At the date of hearing, the appellant had not lived with his family members for three years because he had been first in prison, and later in a probation hostel during the period of his licence. The First-tier Judge found, on the facts at the date of hearing, that the appellant did not have family life with his parents and sister.

15. The First-tier Judge found that although the appellant's circumstances were compelling, they were not 'very compelling' so as to engage the exception in section 117C(6) of the Nationality, Immigration and Asylum Act 2002 (as amended). She found that the appellant's family had been

exceptionally patient and caring, and that his grandparents also had his best interests at heart.

16. The First-tier Judge held that it would not be unduly harsh for the appellant or his minor sister if he were to be deported. She considered that there would be no significant difficulty for this appellant in reintegration in Zimbabwe, and that he could live with his grandparents, who clearly cared about him. His mother was not yet a British citizen at the date of hearing before the First-tier Judge. The judge considered that the appellant's mother could travel to Zimbabwe with him to settle him in.

17. The First-tier Tribunal rejected the Article 3 claim and also considered deportation to be proportionate, with regard to Article 8 ECHR. The appeal was dismissed.

18. The appellant appealed to the Upper Tribunal.

Permission to appeal

19. Permission to appeal was granted on the basis of an arguable error by the First-tier Judge in the treatment of the appellant's medical evidence, and inadequate reasoning in relation to the appellant's health issues.

20. By a decision dated 16 October 2019, Mr Justice Stuart-Smith and Upper Tribunal Judge Kebede set aside the decision of the First-tier Judge, but preserved the findings of fact set out above. The Tribunal considered that the First-tier Judge's treatment of the medical evidence was flawed and did not adequately address the issue of the support available to the appellant in Zimbabwe and the impact upon him of lacking such support:

> "17. …The judge has made appropriate findings of fact in relation to the appellant's circumstances and family and private life ties, which have not been challenged. The errors in the judge's decision arise from her assessment of the medical evidence, and the impact of the appellant's condition and the availability of medication and care upon his deportation. That is a matter which can be considered by the Upper Tribunal. The Tribunal would be assisted by further, and up to date, evidence of the availability of the relevant medication and care facilities in Zimbabwe, including information about available, alternative medication."

21. Following a transfer order, the matter came before me on 1 July 2021. There had been a change of circumstances and I adjourned the hearing for the following reasons:

> "8. The medical and country evidence on the appellant's side was not introduced promptly. His antipsychotic medication until recently was paliperidone, which he received fortnightly as a depot injection. I bear in mind that his arson offence in 2015 was committed at a time when he was not taking his oral antipsychotic medication regularly, and that he has had a regime of depot injections since then.

> 9. In May 2021, the appellant's schizophrenia was bad. He was stressed by his hostile auditory hallucinations, which had lasted for 7 years by then. He made a serious suicide attempt. The appellant was briefly hospitalised and his depot medication was changed from paliperidone to zuclopenthixol decanoate. The new medical evidence says that it will be some weeks before the full effect of zuclopenthixol is known.
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> 10. It seems that his solicitors were not made aware of the suicide attempt or the new medication until last Friday, 26 June 2021. They obtained medical evidence over the weekend, which was submitted yesterday to the Upper Tribunal and the respondent: it includes a recent medical report from Dr Piyal Sen, consultant forensic psychiatrist, and statements from family members who wish to give evidence (though they are now a year old, and need refreshing). The appellant also produced with an updated report from Dr Munyaradzi Madhombiro in Harare as to the availability of medication in Zimbabwe, which is unfortunately not dated.
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> 11. Given the need to consider the appellant's situation as it is at the date of decision, I consider that it is in the interests of justice to admit the new evidence.
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> 12. If it were not that the late evidence included a change in the appellant's treatment regime, I would not have acceded to Mr Melvin's adjournment request. The need for updated MedCOI evidence is plain in the October 2019 decision of the Upper Tribunal setting aside the First-tier Tribunal decision. The appellant's vulnerability and his mental health problems have been a feature of this case since the beginning and were taken into account by the sentencing judge as London ago as 2016. The respondent could and should have commissioned updated country evidence in good time for the present hearing.
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> 13. I am satisfied, however, that it is in the interests of justice in this appeal for all the medical and country evidence to be properly up to date for the remaking hearing, and for an adjournment to be granted for that purpose. I remind myself, also, that the Article 3 ECHR test has been modified by *Paposhvili* (see *AM (Zimbabwe) v Secretary of State for the Home Department* [2020] UKSC 17 (29 April 2020)) and that the First-tier Tribunal did not have the benefit of the guidance therein."

22. That is the basis on which this appeal came back before me for substantive remaking today.

Upper Tribunal hearing

23. Both representatives provided a skeleton argument. The respondent has served an updated MedCOI note and the appellant's representatives prepared a bundle of almost 400 pages of documents, including some additional late-filed documents.

24. It is common ground that the appellant has returned to live with his family members. Mr Lindsay accepts that given the changes in the factual matrix since the First-tier Judge's decision on 28 March 2019, the finding by the First-tier Judge as to family life is now moot.

25. The appellant does not work: he has no permission to do so since his deportation order, but it is not suggested that he has worked before that. He is pursuing online studies for a quantity surveying degree. The appellant continues to receive his anti-psychotic medication by depot injection, rather than relying on remembering to take it, but he now receives zuclopenthixol decanoate, not paliperidone.

26. Zuclopenthixol decanoate, which he has been receiving for about three months, has proved a more successful treatment for the appellant. His sleep is better, with fewer hallucinations, and he is better able to overcome the negative voices in his head, although they are still audible to him. The country evidence is that before the pandemic took hold, zuclopenthixol decanoate was available in Zimbabwe and reasonably priced, unlike paliperidone, which was an extremely expensive drug which would have had to be specially imported into Zimbabwe at prohibitive cost.

27. The appellant has a gold standard care regime in the United Kingdom. His mother, who is a nurse, keeps a close eye on his symptoms and is there to help him if he is anxious or in difficulty. His father keeps in close touch with the care coordinator and the team who look after him, and will do anything for his son. The appellant spends quality time with his sister and is able to support her with her education. The appellant receives his antipsychotic depot injections every two weeks, and sees his care coordinator every month. He is due to have his medication reviewed tomorrow.

28. The issue for the Tribunal is the risk to the appellant's health if he is deported to Zimbabwe now, which must be evaluated with reference to country and medical evidence, and the evidence of his family members.

Appellant's evidence

29. The appellant adopted his previous evidence, which was taken into account in the decision of the First-tier Tribunal. He also adopted his most recent witness statements of 18 June 2020 and 8 September 2021.

30. In his June 2020 statement, the appellant said that when his licence expired, he left the probation hostel and moved back in with his parents, who had bought a 4-bedroom house in June 2017. He had his own bedroom. Typically, his day would begin with waking up at 5 am. He would clean his room, pray, and then walk through greenery to meet his mother from her night shift as a nurse. The appellant and his mother would prepare breakfast for the family, if his sister and father were home.

31. The appellant would then work on his poetry, or read, until he was ready to prepare his own lunch, and then read and study in the afternoon. Four times a week, he made time to go to the gym in town and exercise. His favourite part of the day was between 6 and 7 pm, when the family would gather to eat a meal prepared by the appellant's mother, talking, laughing

and enjoying each other's company. They would then all sit together to watch television until 10.30 or 11 p.m.

32. The appellant had always been very close to his family and they had been supportive. When he was in prison, the journey to visit him was 2 hours each way, but they came every week. They forgave him for what he had done. His mother, a nurse, was 'a pillar in my life' and was able to support him if he felt more anxious than normal, reassuring him when the auditory hallucinations were bad.

33. The appellant had grown closer to his sister, helping her to study for her GCSE examinations. He enjoyed time working with his father in the garden, just the two of them. The family would go together to movies, museums and restaurants. There were immediate cousins, an aunt and an uncle living just 10 minutes away. The appellant pursued his online studies, and at the weekends, undertook voluntary work cooking and cleaning for vulnerable members of the Brent community at his local mosque.

34. The appellant said that he would find reintegrating in Zimbabwe very challenging without his family. Telephone calls between Zimbabwe and the United Kingdom could be very costly, mobile telephone reception was poor in his grandparents' home area, and he was unsure whether he would get the correct medication to keep him well. His grandparents loved him, but they had never had to care for him when he was ill. They were elderly now and he did not think they would cope if he experienced another psychotic breakdown while living with them.

35. In his statement dated 8 September 2021, the appellant said that his father also had mental illness issues and understood what the appellant was going through. His father was supportive, and had worked at home two days a week since the Covid pandemic began.

36. His mother made sure the appellant got the right food, exercise, and sleep. She gave him good advice if he was feeling overwhelmed or having trouble sleeping. His sister was also a good support. They prepared meals and watched films at home together: before Covid, they used to go to the gym together as well. He would hate to be separated from her.

37. His family was a vital support, giving him a different perspective and cheering him up when he was down. His general medical practitioner was also supportive, helping him get transferred back to his local Community Mental Health Team and ensuring that he got regular medication reviews. On his new medication, the negative auditory hallucinations were quieter, less aggressive, and less frequent.

38. The appellant attended mosque every Friday, continuing with his studies, and helping with the local soup kitchen. He had become friends with a neighbour, and went sometimes to the man's house for a meal. The

appellant's faith was very sustaining. He was hoping for a future where he was fully well and 'able to maintain a good length of time in good health without relapsing'. His parents and his sister had the experience of living with him and understood his condition.

39. The appellant's statement concluded:

> "9. I am also confident that my mental health team are doing all that they can to find the best treatment for me, and that they are always considering all options, including the latest treatment. This gives me hope that I can hope to have a normal life one day. When I think about being sent to Zimbabwe, I lose all hope of a future. I would be separated from my parents and my sister. My grandparents have no experience of living with me as an adult. They have never seen me going through a psychotic episode. They last saw me when I was [a] child. They are getting old, and they need support themselves. I have heard that the economy is getting worse. The impact of Covid-19 has made things worse with shortages of food, fuel and medicines. I would be isolated and alone without my parents and my sister who understand my condition, and without my medication to manage my symptoms."

40. In oral evidence, the appellant was asked some supplementary questions by Ms Akinbolu. He confirmed that his mental and physical health on the new medication was better, and that his sleep pattern had improved, with fewer auditory hallucinations, although the voices were still there. His sister had finished school and was now pursuing an 18-month course in Business Studies at the local college, which would finish in December 2022. She still lived at home with the family.

41. In cross-examination, the appellant said that he had not checked whether he could continue to pursue his online quantity surveying course from Zimbabwe. Internet access in Zimbabwe was poor, with no broadband and the electricity always going off. He thought it would be very difficult. His grandparents lived in a township and he spoke to them 'pretty much every week', over WhatsApp.

42. The appellant's understanding was that there was not much work in Zimbabwe because the economy was in bad shape. Although he had processed a number of big changes such as his imprisonment, returning to the community, moving to and from his parents' house and so on, going back to Zimbabwe to stay with his grandparents would be completely different. Zimbabwe would be a new culture, a new system, and there was no established care plan for him there.

43. The appellant accepted that his mother had returned to see her parents in Zimbabwe (his grandparents) on a number of occasions in the past. However, it would not be financially possible for the appellant's mother to accompany him to settle him in if he went to Zimbabwe: she would not get the time off and with the present costly quarantine requirements it would

not be affordable. In any case, since it would only be temporary, that would just postpone the problems.

44. In re-examination, the appellant said that when his auditory hallucinations were bad, he would try to listen to something else, to try to help him relax until he was sufficiently exhausted to sleep. He had returned home in August 2019. His symptoms were better, but in 2019, it had still been necessary to increase his previous depot medication from 100 mg to 150 mg. That helped for a short while but he quickly got used to it and in 2021, the decision was taken to change his medication.

Family members

45. The appellant's father made a number of witness statements. Again, only the statements of 22 June 2020 and 9 September 2021 are relevant today, the earlier ones having already been taken into account. In his June 2020 statement, the appellant's father confirmed that the appellant had moved back home in August 2019. The family were happy to have him home and to be able to keep him safe. His mental health was a lot better than before he went to prison. The appellant's father was able to support him in his Surveying degree studies, because that was his own profession.

46. The appellant listened now when the family gave him advice, and it was possible to have meaningful conversations about his future and his life issues. He was focused on his studies and helped his father in the garden. With family support and guidance, he was no longer drinking alcohol or taking drugs. The siblings enjoyed each other's company: the appellant helped his sister with her schoolwork, attended meetings at her school, and was helping her with 'A' level choices. The statement concluded:

> "I fear what would happen to [his] health if he were to lose our support. We understand the support that he needs, and my wife is able to support him with his medication and his treatment plan, because she is a nurse. We are [his] parents and we have lived through the worst of his experiences with him. We will always be here for him and it is clear to me that he still needs us."

47. In his September 2021 statement, the appellant's father explained that his son had taken an overdose of paracetamol and aspirin in June 2021, in a suicide attempt. The auditory hallucinations had been particularly bad then. The appellant had been kept in hospital overnight then transferred to the mental health ward. The family were relieved when he was well enough to come home. The appellant was struggling now with the online course and his grades had dropped considerably.

48. The core of this statement is in [2] and [4]:

> "2. …We live with [my son] and can report when he is coping, and when he is not coping. I am aware that he worries about his immigration case. Not knowing how it is going to end. I can see the look on his face when he sees news reports about deportation flights come on the television news

programmes that we watch together. This worries him a lot and makes him anxious. …

4. I would like to see [my son] being active again. I would like him to enjoy his life. I would like him to complete his studies and find work. Although he is struggling right now, at least we are there to support him. We speak to my parents in law almost every weekend. They cannot do much for [my son]. They look up to us for their upkeep. We are the only ones that can look after [him]. We know about his condition. We know what to look out for when he is having a relapse. No one else can do that. Certainly not my parents in law at their age."

49. In oral evidence, the appellant's father said that he did not think that his son was in a position to live alone, or would be able to do so. The family gave him all the support he needed, day by day, and the father kept in touch with the appellant's care coordinators. Sometimes the care coordinator came to the house to see how the appellant was doing, as well as his monthly visits and his fortnightly depot injections. Since the appellant had returned home in June 2021 after his suicide attempt and being in hospital, the family had continued their support, letting him know that they were there for him. With all the support they, and the community, were giving, the appellant was coping well.

50. The appellant's parents considered that his maternal grandparents would not cope with him in Zimbabwe. They were elderly, and not used to spotting the symptoms and knowing when to help. The appellant got very stressed sometimes, and had periods of not sleeping. His family would support him, reassuring him that whatever he needed, they would help, and talking him through his anxiety. They would let the care coordinator know of any problems, especially the not sleeping, which his father considered was now affecting his son's studies.

51. They had all lived together as a family for so many years: even when the appellant was in prison, the family visited every week, and when he was in the probation hostel they would visit, or he would come and spend the day with them, returning in time for his curfew. The appellant's father said that when his son was sentenced, one of the judges said he should be living at home. What had happened, happened because he was not well and had a relapse. He needed the family's support.

52. There was no re-examination.

53. The appellant's mother attended court but did not give evidence. She also made statements in June 2020 and September 2021 which have not been previously considered. She said in the June 2020 statement that she monitored the appellant every day, keeping an eye out for side effects of his medication and for changes in behaviour, which might be a sign he was relapsing, bringing them to the attention of the medical team to get him the right treatment at the right time. The appellant needed close monitoring to ensure he stuck to the treatment plan, exercised, ate the right foods and got sufficient sleep.

54. The appellant had phases, including one recently, where he could not sleep for days. His mother and father would reassure and counsel him, helping him to return to normal sleeping:

> "5. ...When he gets anxious, it helps that he is able to have his mother and father nearby to reassure him that everything will be all right. He listens more to our advice than he did before, and I can see that he is committed to keeping himself well.
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> 6. I go food shopping with him and we enjoy cooking together. I help him to pick out his food. He eats a halal diet, so some of the food he eats is different to what the rest of the family eats. He often collects me from work early in the morning, after I have completed my night shift. We walk the 20 minute walk home together. It is during these times that we get to talk to each other as mother and son. [My son] has matured so much, and he values the family support and the time he gets with us as a family. He is very close to his sister...who is now 16 years old. He helps her with her schoolwork. They spend time watching films together and spending time together, hanging out as brother and sister.
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> 7. [He] needs our family support at home. He remains vulnerable and as a nurse, I am aware that he needs to take his medication, keep a regular routine, and that he needs the family support for him to be as well as possible without him relapsing."

55. In her September 2021 statement, the appellant's mother gave details of the suicide attempt in June 2021. It was she who had found the appellant and called the ambulance. The appellant was so vulnerable at present: he could not be left without support 'because things can become very bad for him very quickly when his mental state deteriorates'. He still needed a great deal of support and reassurance from the family and his mental health team.

56. The appellant's mother's statement concluded:

> "6. If [he] is sent to Zimbabwe, I really fear what would happen to him, because we would not be there to look out for him. My husband and I have to remain in the United Kingdom to support our daughter, who is still in education. We intend to support her with her further education. We want to support both of our children.
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> 7. My mother is 66 and my father is 70. Like most people, they are struggling in Zimbabwe and the impact of Covid-19 has made things worse. I speak to my parents once a week, and we send money to support them. They rely on the money we send them to survive. I fear that [my son] would be too much for them to cope with. They would not have the support from a mental health team like we do here. Zimbabwe remains on the red list under the United Kingdom's Covid travel regulations, which means that it would be virtually impossible for us to even visit him, given the mandatory minimum of 10 days' hotel quarantine in the United Kingdom on our return at a very high financial cost. My work commitments wouldn't allow this to happen.

> 8. I am hoping that [my son's] mental health team in the United Kingdom is able to find suitable medication to manage his symptoms. I hope that [he] succeeds in completing his studies, because he works so hard. He is determined to make the best of himself. He complies with his medication and attends all his appointments. He is able to do so because he has our support, and the support of his mental health team. If he loses this support, I fear that my son's condition would deteriorate and that we would never get him back."

Mr Lindsay did not ask to cross-examine the appellant's mother.

57. A letter of support from the appellant's sister has already been taken into account. She is now undertaking a course in Business Studies at the City of Oxford College.

58. There was no evidence from the appellant's maternal grandparents.

Sentencing remarks

59. When sentencing the appellant on 4 March 2016, Mr Recorder Clark noted that both his parents were present in court, which he said 'bodes well for the future'. He took into account a supportive and complimentary pre-sentence report and an addendum psychiatric report by Dr Agarwal. The appellant had pleaded not guilty throughout. The appellant had set the fire after a dispute with his father, having not taken his depot injection for 6 or 7 weeks. He told the jury that he did not have the fare to go to the clinic. The judge considered that 'a lame excuse in hindsight bearing in mind the consequences of that failure'.

60. The appellant left the burning building but went back in and was rescued with his father, through the upstairs rear window. There were three mitigating factors: the appellant's previous good character (apart from a minor matter some years earlier); his mental and medical condition; and the fact that no accelerant was used. His mental health issues were caused by his use of cannabis and skunk from the age of 13.

61. The judge considered the case not to be one of 'true revenge' but rather of spite or pique after a domestic argument. There were no sentencing guidelines for the offence of arson reckless as to whether life would be endangered. After reviewing relevant case law, the judge decided that the appropriate starting point was 4 years' custody, with no credit for a guilty plea, as the appellant had never shown any remorse. The remarks continue:

> "I had considered the question of an extended sentence which would have left open the possibility of an extended supervising licence at the end of the term, which is clearly what is needed, er, in this case, but Dr Agarwal and the Probation Officer say that it is not their opinion that you are dangerous as defined in law, so even if the sentence had been longer than the 4 years, I would not have come to the conclusion that an indeterminate sentence was appropriate.

> Finally, there's the question of supervision and treatment after your, er, release. Well I've read, er, about the regime that you will be subject to when you're released from the sentence, er, that I have imposed and I'm very glad that clearly a very close eye will be kept on you on – and your behaviour by the doctors who care for you. And I very hope – very much hope that they will realise the serious responsibility which lies on them in relation to your future behaviour. …
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> Finally, I'd just like to say to your parents, thank you very much indeed for coming. I hope you continue to support your son who clearly has very great difficulties. He must take his medication, he must not take drugs. Er, the sentence that I've had to pass, um, gives me no pleasure whatsoever, but I've done my best to explain on the decided cases why a sentence of at least that length is necessary. …"

Pre-sentence report

62. The pre-sentence report prepared on 2 March 2016 recorded that the appellant did admit to setting the fire intentionally, but noted his 'deep regret'. He had apologised to his father and gone back into the building to wake his father up so that he would not be killed. He had resolve to take his medication properly, to stop smoking skunk and cannabis, and not to be in possession of lighters, to show his parents he was making a concerted effort to 'remove the threat'. He was engaging with the medical team in the custody setting and realised he needed to remain abstinent from alcohol and illegal drugs in future.

63. The appellant had a conviction for battery in November 2015, having pushed a pub landlord when in Leeds. In January 2015, he had on three occasions been violent to his mother, father and sister, when he was experiencing command hallucinations ordering him to harm people.

64. His family members were those most at risk but if he committed fire setting again there would be a risk to neighbours and the general public also. He had demonstrated remorse. His risk of reoffending was not considered imminent whilst he was medicated and engaging with medical services. He did not meet the threshold for Dangerousness.

65. On release, as recommended by Dr Agarwal, the appellant would require a formal transition between medical services in custody and the community, and strict MAPPA and licence conditions during any period of supervision on licence by the National Probation Service.

Medical evidence

66. The report and supplementary repot of Dr Pankaj Agarwal MBBS MRCPsych is consistent with the pre-sentence report above and has already been considered.

67. Dr Piyal Sen MBBS DPM FRCPsych Dip Forensic Psych is a consultant forensic psychiatrist who was a Clinical Lecturer in Forensic Psychiatry at the Institute of Psychiatry (the academic wing of The Maudsley), as well as

St Bartholomew's and the Royal London School of Medicine and Dentistry. He is an examiner for the Royal College of Psychiatrists and a member of its Refugee and Asylum Working Group, in which role he has given evidence to outside bodies such as the All-Party Parliamentary Committees and the Shaw Enquiry. He supervises student dissertations at both undergraduate and postgraduate level at King's College London. Dr Sen is well placed to assist the Tribunal.

68. Dr Sen has prepared a number of reports on this appellant's health and circumstances. The first was dated 12 February 2019 and predated the appellant's release from prison. It recommended the involvement of the Community Mental Health Team, and that the appellant should live at home and his parents receive support from the Team, especially his father, whose own mental health problems had recently flared up.

69. Dr Sen's second report was amended on 13 May 2020 and is up to date to that date. He had available a report from Dr Munyaradzi Madhombiro on the availability of the appellant's then medication in Zimbabwe. He also saw the MedCOI evidence relied upon by the respondent.

70. Dr Sen was concerned that the appellant still had symptoms, despite treatment, but noted that the appellant had published a book of poetry and completed a foundation course in Quantity Surveying. The appellant was free of drug and alcohol use, but Dr Sen's prognosis was 'guarded based on his partial response to ongoing treatment' and the stress caused by his awareness of the deportation issue. The risks to the appellant were manageable only with close monitoring by a Mental Health Team and in the event of deterioration, 'there should be a low threshold for admitting him to hospital for stabilisation of his illness'.

71. The appellant perceived deportation to Zimbabwe as 'an extremely negative life event' which would significantly increase the chance of a relapse. Dr Sen's report concluded:

> "5.5 …I note that his antidepressant was stopped at his own request in December 2016, but had to be restarted after approximately 6 weeks due to a deterioration in his mood. He was also on oral Risperidone about 5 or 6 years back, but was missing some doses and suffering a relapse, after which he was switched to depot Paliperidone. This suggests that he is highly sensitive to the availability of medication and his condition is likely to deteriorate if he was not on the medication.
>
> 5.6 [The appellant] stays with his family currently, and feels that their support, particularly from his mother and sister, as well as his aunt and a cousin, helps to cheer him up, as they all live in the same area; he describes this support as 'a massive help'. Apart from a deterioration of the symptoms of his paranoid schizophrenia, there is also the high risk of a deterioration of his mood and anxiety, without the support he derives from his immediate family. He himself described that his grandparents, who live in Zimbabwe, were in their seventies and they needed help themselves, which they get from [his] cousins, and his grandparents would thus be in no position to help him. [The appellant] would thus perceive any separation

> from his parents and sibling as an extremely negative life event, and this would increase the chance of a deterioration of his mental health condition and the attendant risks."

72. Dr Sen's next report was on 17 August 2021. By this time, the appellant was on Zuclopenthixol 600mg, by fortnightly depot. He had gained some weight, was sleeping better, and might soon be able to resume his participation in a cognitive behavioural therapy trial for psychosis, using virtual reality. The full effect of Zuclopenthixol would not be known until he had been taking it for about three months. An alternative medication was possible, Clozapine, but that needed regular blood tests and the appellant, although more open to the idea, preferred to avoid it.

73. Dr Sen found that there was an improvement in the appellant's health, despite his recent suicide attempt and hospital admission, which he considered 'strongly suggests that [he] could be extremely vulnerable in case of any non-compliance with his antipsychotic medication regime', which should be noted for the future.

74. The appellant was fit to testify and participate in a face to face hearing, and had faith in his legal team. He might need appropriate breaks if he was feeling 'somewhat distressed' and particularly if his auditory hallucinations became more intrusive. He would need to have questions put slowly, and to be given enough time to answer. A family member's presence, to offer appropriate support, would be helpful, and the family should ensure that he had a good night's sleep before the hearing. With these adjustments, the appellant would be able to participate fully in the hearing.

75. On 16 September 2021, Dr Sen prepared a further report. He noted that the medication currently being taken by the appellant was available in Zimbabwe and that some arrangements might be made for a nurse to follow him up in the community. However, there was no mention of a crisis team or a professional available to him in the community. There was more to the treatment of a severe mental health condition like paranoid schizophrenia than medication: the psychological support, provided here by a community care coordinator the appellant trusts, a psychiatrist he knows, and his family, in the family home, was equally important.

76. The core of Dr Sen's professional opinion in this latest report was this:

> "3.2 The much broader concern for me is the change in circumstances for [the appellant] while he continues to suffer from a severe mental illness like paranoid schizophrenia. He is highly vulnerable to relapse following any serious psychosocial stressor, and he would perceive a return to Zimbabwe as such a severe stressor. This is not only due to his unfamiliarity with the country, it is also due to a breach in his support system, as he himself acknowledges that he is highly reliant on the support provided by his family, including his parents and sister, who provide emotional, financial and moral support for him, which helps to greatly reduce his stress, thus preventing relapse.

> 3.2 …Even if the biological elements of his treatment programme are available in Zimbabwe, a breakdown in the psychological and social elements of his care will significantly increase the chance of a relapse and increase his risk of self-harm and suicide. This issue needs to be borne in mind when considering his asylum appeal."

77. That concludes Dr Sen's very helpful professional assessments of this appellant's health risks and condition.

Country evidence

Dr Madhombiro's report

78. The appellant relies on a report by Dr Munharadzi Madhombiro, MBChB DipMH MMed PhD (Psych), a registered Specialist Psychiatrist practising in Harare, Zimbabwe. Dr Madhombiro studied at the University of Zimbabwe, obtaining his Bachelor of Medicine and Surgery (MBChB) in November 1994, his Diploma in Mental Health (DipMH) in November 1999, and his Masters in Medical Psychiatry (MMed) from that University in November 2002.

79. He worked in the Psychiatry Department of Harare Hospital from January 2003 until he left Zimbabwe for South Africa in the summer of 2015, to pursue his doctoral studies at Stellenbosch University, Cape Town, returning to the University of Zimbabwe in Harare in May 2016 for a further three years as a trainee with the Junior Faculty Research department. In November 2018, Dr Madhombiro obtained his doctorate from Stellenbosch University, before travelling to the Buffalo Campus of the State University of New York where from 2018 to date, he has been a post-doctoral fellow in the NeuroAIDS programme.

80. It follows that Dr Madhombiro's information about the system in Zimbabwe is up to date to 2018, but thereafter is based on what he learns from others or the media. His report is dated 8 March 2019. Dr Madhombiro had not seen the appellant, but his self-direction as to the patient's history was concise and to the point:

> **"2. Summary of case.**
>
> The documents I perused and especially Dr Sen's report indicates that [the appellant] suffers paranoid schizophrenia which is complicated by alcohol and substance abuse. Further, he is an individual whose care involves multiple agencies and even with that, he is at risk of further relapse. He needs a community plan that requires the involvement of a psychiatrist, a community care coordinator, a drug and alcohol service, a social worker, and access to suitable occupational and rehabilitative opportunities. His pharmacological treatment includes a depot injection that is given 2-weekly, was on mirtazapine 30mg at night over and above the community resources."

81. The appellant was still on the expensive paliperidone treatment when this report was written. I do not therefore take account of Dr Madhombiro's

observations about medication availability. The core of his conclusions is this:

> "6.5 [The appellant] will likely be admitted at the Harare Central Hospital Psychiatric Hospital as it is the only medium secure unit in Harare which can take patients from [his home area] ...
>
> 6.7 Zimbabwe currently provides no community mental health service, so [the appellant] will not receive much support other than the support from the grandparents.
>
> 6.8 It is unlikely that [the appellant] will receive any support for his mental health in [his home area]. In the event that he has a relapse and requires long term treatment, he may have to be moved to the National Psychosis Centre in Bulawayo, a city 400km away from [his home area].
>
> 6.9 In the early stages of the appearance of psychotic symptoms, the patient is managed as an outpatient of the two acute units in Harare, that is Parirenyatwa Annexe and Harare Hospital Psychiatric Unit. There are no community follow up services, so any deterioration in condition, the patient gets admitted to the central hospital. Where the evaluation finds that the patient is dangerous to others, the patient is received in a correctional facility [prison] based institution. At the institution, the patient is subject to the provisions of the Prisons Act and the Mental Health Acts."

82. In a supplementary report which is undated, Dr Madhombiro gave details of pastoral care facilities in Zimbabwe and the available medical treatment, responding to the MedCOI report previously relied upon by the respondent. He said this:

> "**1. Please describe what if any pastoral care facilities are available in Zimbabwe for a person with [this appellant's] condition and with his diagnosis. This includes services available as an outpatient and in the community for the person's emotional support and wellbeing.**
>
> Mental health services in Zimbabwe are governed by the Mental Health Act. The Mental Health Act does not include pastoral care as part of routine care, and as such, will not be available in the government service for the cases that require this service. [The appellant] will thus be unlikely to receive care organised specifically for him. Zimbabwe does not have community based outpatient care specifically for mental health, but has a primary healthcare system which is however under developed to provide [for] individuals with severe mental illness like [him].
>
> 2. **Please refer to the MedCOI report at pages 1-2 which lists the availability of medical treatment in Zimbabwe. Is this information accurate and up to date?"**
>
> This information on MedCOI is grossly inaccurate and refers to services that are provided by private pharmacies, who import medications directly. This is however severely curtailed by the shortage of foreign currency. While psychiatrists, psychologists and nurse practitioners are available in Zimbabwe, these are in academic institutions, and the country of about 15

> million population has 17 psychiatrists and only 4 psychologists in public services, mainly the academic institutions. In terms of the listing of the personnel available, the points 1.1.1 in MedCOI [are] thus accurate. Psychiatrist and psychologist consultations are available but limited to academic institutions. …"

83. I have not placed any weight on the discussion in this report of the difficulty in obtaining the appellant's previous depot medication.

Response to Information Request: 13 September 2021

84. Following directions by the Upper Tribunal, the respondent sought up to date MedCOI information on the support available in Zimbabwe, which is set out in a Response to an Information Request entitled *Zimbabwe: Psychiatric treatment* reference 07/21-009, dated 13 September 2021. The respondent has not had access to MedCOI since 31 December 2020, presumably for EU Exit reasons, so the information therein contained is almost a year old.

85. The respondent's Response relies on a MedCOI response of May 2020 for another appellant, which stated that where a psychiatrist was required, inpatient treatment is given at Harare Central Hospital, with outpatient treatment at Parirenyatwa Hospital in Milton Park, Harare. Both are public hospitals. Any psychotherapy, or cognitive behavioural therapy, also takes place at Parirenyatwa Hospital. Inpatient and follow up treatment by a psychologist is at Harare Central Hospital, together with psychiatric day care.

86. On the question of community care, the report said this:

> "2.1.2 CPIT [the Country Policy and Information Team] asked whether there are mental health nurses in the community (in Harare and surrounding area) who can ensure that patients are following doctors' orders and would assist patients with administering depot injections etc. A doctor in Harare informed the [British High Commission] that *he knows a nurse with a degree in psychology* who is happy to do house calls and oversee patient's medication as requested. However, CPIT is not able to advise on the general availability of such assistance."
>
> [*Emphasis added*]

87. The Migration Delivery Officer at the British High Commission in Pretoria, South Africa, had reported that at two pharmacies in Harare, the medication which the appellant presently receives, Zuclopenthixol Decanoate in injectable form, was available in fair supply, and easy to obtain at a cost of US $20 for an unspecified quantity. The same officer advised that psychiatric services were free to some extent, including services and consultations.

88. However, although medication was generally free, at Parirenyatwa Hospital, one of the biggest referral hospitals in Harare, a nominal fee would be charged to outpatients, inpatients and institutionalised patients

for their medication, despite the Mental Health Act & Policy 1996, which stated that mental health was to be treated without charge, and funded by the government.

Home Office Country Policy and Information Note

89. The respondent issued an updated CPIN in April 2021 entitled *Zimbabwe: medical treatment and healthcare.* The section on mental health and psychiatric care is at [5] and is based in part on a research paper published in The Lancet Psychiatry in November 2017, which itself was based on research in 2016, on the World Health Organisation's (WHO) Mental Health Atlas for 2017, published in 2018, and on a DFAT Australian country report from 2019, as well as the May 2020 MedCOI report mentioned above.

90. None of the underlying information is more recent than 2019. Zimbabwe relaunched its mental health strategy in 2019 for the period 2019-2023, according to a WHO press report on 2 April 2019. No copy of that report appears in the bundle but it seems to have been in general terms and to be aspirational rather than recording any current improvements in mental health provision.

91. The 2019 DFAT report is quoted at 5.1.10-5.1.1:

> "Despite considerable need, there are limited facilities and services available for those with mental health issues, and NGOs report that getting access to mental health services is generally slow and frustrating. There are few certified psychiatrists working in public and private clinics and teaching in the country. A shortage of drugs and adequately trained mental health professionals mean that those with mental health issues are often not properly diagnosed and do not receive adequate treatment. …
>
> There are eight centralised mental health institutions nationwide, with a total capacity of more than 1300 residents, in addition to three special institutions that house long-term residents and those considered dangerous to society. Residents in the eight centralised institutions receive cursory screening, and most wait for at least a year for a full medical review. Prison inmates with mental health issues routinely wait for as long as three years for evaluation."

92. That information appears to have been extracted from the US State Department Report which is cited at 5.1.12. The US State Department Report on Zimbabwe for 2020 (based on the situation in 2019) gave additional information, also quoted in the April 2021 CPIN:

> "…In the informal sector, the Zimbabwe National Traditional Healers Association (ZINATHA) played a large role in the management of psychosomatic and anxiety disorders. ZINATHA conducted training for its members to learn to refer patients with mental health problems to the formal sector.

> *A shortage of drugs and adequately trained mental health professionals resulted in persons with mental disabilities not being properly diagnosed and not receiving adequate therapy.* There were few certified psychiatrists working in private and public clinics and teaching in the country. NGOs reported that *getting access to mental health services was slow and frustrating. …* "
>
> [*Emphasis added*]

93. The CPIN recorded at 5.1.21 that the US Embassy's non-exhaustive list of medical practitioners and facilities for use by American citizens visiting Zimbabwe, updated 6 February 2020, included just one psychiatrist, Dr Chagwedera, in Harare.

Press reports and other evidence

94. The evidence above relates to the situation in Zimbabwe before the Covid-19 pandemic which began in early 2020 and continues. A press report from Al Jazeera dated 28 April 2021 is entitled *Rich or poor, in Zimbabwe crumbling healthcare is deadly for all,* recording that under lockdown, unable to fly out and seek medical treatment in other countries, Zimbabwe's wealthy were now obliged to take their chances in local hospitals alongside everyone else. The article principally concerned the difficulties in obtaining cancer treatment in Zimbabwe. It stated that an estimated 20,000 Zimbabwe citizens had spent US $4 billion on medical tourism since 2011, mainly in India. In 2019, the finance minister, Professor Mthuli Ncube, commented that Zimbabwe was losing millions of foreign exchange each year to medical tourism.

95. In September 2020, Zimbabwe's health minister, Constantin Chiwenga promised to ban health tourism and to improve health facilities within the country, but nothing had been done and 'the healthcare system remains dilapidated', with just $21 per citizen spent on healthcare in 2020. Consequently, the country's Covid-19 response had been poor.

96. Dr Mthabisi Bhebhe, a government medical officer at Plumtree District Hospital, in southwestern Zimbabwe near the Botswana border, spoke of the decaying healthcare facilities there, which were similar to those in most hospitals in Zimbabwe:

> "The current health system in Zimbabwe is in crisis. Covid-19 has made obvious all the shortfall in the system, poor funding, corruption, shortage of health workers and lack of adequate vital medicines, poor referral system and dilapidated health infrastructure. …
>
> *The ordinary man in Zimbabwe is generally unable to enjoy their constitutional right to access healthcare*."
>
> [*Emphasis added*]

80% of the population was turning to home remedies and traditional herbal medicine for its immediate health needs, together with steam bathing.

97. On 24 May 2020, a report in the Global Press Journal by Gamuchirai Masiyiwa, senior reporter, said that prices of medicines had doubled since the pandemic:

> "Stocking a pharmacy in Zimbabwe was difficult long before the threat of the coronavirus shut down the country on March 30 [2020]. … The country relies on India, China and South Africa for nearly all of its medical supply imports, which include drugs and medical consumables such as personal protective equipment, syringes and catheters. …"

98. A pharmacist is quoted as saying that with the border to South Africa closed and air traffic now severely limited, drugs of which he normally had plenty on hand, particularly those for high blood pressure and cholesterol, had run out, leaving many customers vulnerable. Zimbabwe had once manufactured drugs locally but now bought 80% of its medicines and drugs from India. The managing director of KDG Healthcare, a pharmaceutical supplier in Zimbabwe, said that he used to pick up a telephone to talk to someone in South Africa and they would deliver what he needed, but this was no longer the case. Another pharmacy owner, Jocelyn Chaibva, said she was unable to stock in-demand drugs and high-quality personal protective equipment.

99. A ReliefWeb Economic Update on Zimbabwe, published on 10 June 2021, confirmed the increasing shortage of staff and medicines. Significant financing would be required to restore service delivery to the levels of the recent past 'as the gap has widened sharply over the past two years'.

Submissions

100. For the respondent, Mr Lindsay relied on his skeleton argument and made oral submissions. The strength of the public interest in deportation corresponded to the seriousness of the offence: see section 117C(2) of the Nationality, Immigration and Asylum Act 2002 (as amended). The respondent reminded the Tribunal of the seriousness of the appellant's offence of reckless arson. The appellant had been found to be a high risk to the United Kingdom public in the OASys pre-sentence report of 2 March 2016 and in an independent psychological report in November 2015.

101. As regards Article 3 ECHR, following the decision of the Supreme Court in *AM (Zimbabwe) v Secretary of State for the Home Department* [2020] UKSC 17, the *Paposhvili* test applied in the United Kingdom. The appellant's appeal could succeed only if he could show that if returned to Zimbabwe he would be exposed to a serious, rapid and irreversible decline in his state of health, resulting in intense suffering or a significant reduction in life expectancy.

102. The Secretary of State relied on the September 2021 *Response to an Information Request, Zimbabwe: psychiatric treatment* and on Dr Madhombiro's evidence in 2019. The appellant's current antipsychotic depot injection, Zuclopenthixol, and the antidepressant he takes, Mirtazapine, were available in 2019 at two pharmacy sites in Harare and

were both easy to obtain and relatively stable in supply. The medication, Procyclidine, which he takes for side effects (stiffness of the muscles and tongue) was not available in Harare but an alternative medication, Trihexyphenidyl, would be available. The particular side effects were not of themselves sufficient to meet the Article 3 test as reframed in *Paposhvili,* or to make removal disproportionate with reference to Article 8 ECHR. Dr Sen had stated that he was 'confident' that the appellant would not try to commit suicide again, despite the attempt earlier this year. The appellant's increased insight into his condition, and his abstinence from drugs and alcohol would also be helpful.

103. In oral submissions, Mr Lindsay relied on the possibility of the appellant's mother returning with him. He accepted that there was a risk of a serious and rapid decline in the appellant's state of health, which might result in intense suffering, but not that such decline would be irreversible. The medication which the appellant currently used was available in Zimbabwe, on the respondent's evidence, and even if physical restraint were required in a correctional facility, that was not sufficient to reach the *Paposhvili* Article 3 threshold.

104. In relation to Article 8 ECHR, Mr Lindsay said that on the evidence, the Tribunal might find that the *Kugathas* standard for family life between an adult child and his parents might now have been established. The appellant was now living with his parents and sister, and his mother, a nurse, had an active role in the management of his symptoms. The question of the appellant's social and cultural integration in the United Kingdom was also moot, given the changes in circumstances since the First-tier Tribunal decision. Mr Lindsay made no concession on either point: it was a question of fact for the Upper Tribunal.

105. The appellant had his grandparents in Zimbabwe, and there were also cousins and younger siblings of his grandparents there. The appellant's father was a well paid quantity surveyor: the family owned a four-bedroom home and had provided no financial evidence to support the appellant's assertion that funds for travel and quarantine would be beyond their reach.

106. The appellant could continue his studies online: there must be some reliable internet, since he spoke every week by WhatsApp to his grandparents. The proper approach was not to compare the care and treatment which the appellant was receiving in the United Kingdom with that which he could have in Zimbabwe, but rather, to look at what other Zimbabwean nationals had available to them.

107. The appellant's offence had strong links to his mental health. The appellant's present medical regime seemed to be available in Zimbabwe: Dr Sen had not expressed any concern as to its availability. The MedCOI response did not say whether it was available in depot form, but if it were not, one would have expected Dr Sen to say so. The complex community plan which supports the appellant and reduces his imminent likelihood of

relapse should be considered as an ongoing risk that he would become unwell again and commit further crimes.

108. Mr Lindsey reminded the Tribunal of the two battery offences in 2015 which had not been taken into account in the sentencing remarks for the arson offence. The appellant had received a 4-year sentence for reckless arson and was in the highest category of offender. The public interest in deportation of the appellant was very high; it included discouraging other foreign offenders and maintaining public confidence in the immigration system. The appellant's personal circumstances were not such as to amount to 'very compelling circumstances' rendering deportation disproportionate. The appellant's deportation would be proportionate in the circumstances.

109. For the appellant, Ms Akinbolu argued that the Article 3 risk was significant: if the appellant were without the enveloping care which he was currently receiving, there was a real risk of a serious, rapid and irreversible decline in his health. Mental ill health was stigmatised in Zimbabwe. The appellant had attempted suicide as recently as June 2021 and been saved by his mother's prompt reaction. Her support and close monitoring, and that of the family and the community and crisis care were vital to his continued health.

110. It would not be practical for the appellant's mother to return with him to Zimbabwe. Zimbabwe was on the Covid red list and she would have to quarantine on arrival, and on return, at considerable expense. If the appellant's mother returned to Zimbabwe with him, she would still have to leave at some point. She had a child, a job and a husband in the United Kingdom. That further change would unsettle the appellant, and the evidence of Dr Sen was that the appellant was extremely vulnerable to any change in circumstances. He would be distanced from his current supportive regime and likely to deteriorate fast.

111. It was for the respondent to show that adequate treatment was available in Zimbabwe but she had not done so. The MedCOI evidence was not up to date and was insufficient. Even if the appellant's depot medication and the rest of his medication remained available in Zimbabwe under pandemic conditions, there was no outpatient regime: it was not sufficient for a single doctor in Harare to say that he knew a particular nurse who would undertake home visits.

112. The evidence of the CPIN and of Dr Madhombiro was that there was no coordinated therapeutic support in Zimbabwe. Economic problems affected the supply of drugs, particularly at present with the Covid situation. Any delay in the administration of the drugs the appellant needed would present stark risks to him. A prima facie Article 3 case was made out and not rebutted by the respondent's evidence.

113. With regard to Article 8 ECHR, the Upper Tribunal should find that family life existed between the appellant and his parents and sister. Even if care

was available in Zimbabwe, Dr Sen's evidence was that given his subjective fear of return, and the change in circumstances, culture and so on, the appellant was likely to relapse if removed. His mother's assistance could not be maintained: she should not be expected to choose which of her children to support.

114. The index offence had occurred during a relapse in the appellant's mental health, which should reduce the weight to be given to the public interest. The appellant had made no deliberate choice but had acted while the balance of his mind was disturbed. A similar offender would not be deterred if acting while suffering a psychiatric illness.

115. Overall, returning the appellant to Zimbabwe would present a real risk of relapse and of a significant negative effect, which was likely to be unduly harsh, for both the appellant and his family members: see paragraph 398 of the Immigration Rules HC 395 (as amended) and Exception 2 to section 117C. The appellant had not lived in Zimbabwe since he was 8 years old, except for two short visits, one to sit his examinations. The stigma in Zimbabwe regarding the mentally unwell would affect his ability to establish relationships, to find a job, and to integrate. There were real challenges to reintegration and removal would be disproportionate on the facts.

116. Ms Akinbolu asked me to allow the appeal. I reserved my decision, which I now give.

Analysis

117. There has been a change in the factual matrix in this appeal since the First-tier Tribunal decision. In the present circumstances, I am satisfied that the intensity of the appellant's dependence on his parents, and his mother in particular, is sufficient to amount to a resumption of family life between him and his parents. I also accept, with some caution, that the appellant has become better integrated here, in that he helps out with a soup kitchen, attends the mosque, and is studying for a degree in Quantity Surveying. He also (in normal times) goes to the gym with his sister regularly.

118. The appellant's mental health continues to be particularly fragile. Dr Sen's evidence is that even with the current medication regime, which is better for him, he still has symptoms and is very vulnerable to any change in circumstances. The evidence of the appellant's parents is that his grandparents are receiving financial support from them and are in need of emotional support themselves. I accept the parents' evidence that the appellant's grandparents have never dealt with him when he was unwell and would probably not be able to cope if they had to do so.

119. The importance of the appellant's family life with his parents, and his mother in particular, is recognised in the respondent's reliance on the assistance which he might obtain from his mother travelling back with him

to 'settle him in'. In the present pandemic circumstances, and having regard to the needs of her daughter and her employment, it is not reasonable to expect the mother to do so and in any event, it would only postpone any difficulty caused by the change of circumstances.

120. The appellant's medication regime seems to have been available in at least some pharmacies in Harare before the pandemic, but the evidence is that the supply chains have been broken since then. Zimbabwe is a red list country and is also in dire economic circumstances. The country evidence, including the 2020 MedCOI evidence and other recent press reports, the WHO, DFAT and US State Department Reports, all indicate problems with medication and support since the pandemic.

121. Mr Lindsay accepts that there would be a serious and rapid decline in the appellant's health if he were returned to Zimbabwe in the present circumstances, save if his mother returned with him, and I find that once his mother returned to the United Kingdom, there would not be adequate medical or social support to prevent the appellant becoming much more unwell than he is now.

122. The question therefore, in *Paposhvili* terms, is whether the damage to his health would be irreversible, and whether it would result in intense suffering or death. I remind myself that when his health deteriorated in June 2021, the appellant attempted suicide. His suffering, when the auditory hallucinations are bad, is properly to be described as intense. If he were not to receive regular depot injections and a high level of support, the medical evidence is that he would deteriorate and irreversible harm cannot be ruled out, up to and including a successful suicide attempt. I conclude, therefore, that the *Paposhvili* test is, just, satisfied.

Article 8 ECHR

123. Section 117C requires deportation where the sentence exceeds four years, as this does. Section 117C(1) states that the more serious the offence committed by a foreign criminal, the greater the public interest in deportation. This was a serious offence: the appellant was sentenced to four years for reckless arson.

124. Article 8 is a qualified right. I must consider whether the appellant's deportation would be disproportionate, having regard to the public interest in his deportation as set out in section 117C of the 2002 Act. In order to establish that removal is disproportionate, the appellant must show not only that either Exception 1 or Exception 2 applies, but also that 'there are very compelling circumstances, over and above those described in Exceptions 1 and 2': see section 117C(6).

125. I have regard to the serious nature of the index offence, but I note that it was committed when the balance of the appellant's mind was disturbed and that he went back into the flat to make sure his father survived. He has not harmed anyone except himself since then. The appellant has not

used drugs or alcohol for at least two years and has not offended again since 2016. His family have supported him throughout and the sentencing remarks noted that he was not considered to be dangerous, either by Dr Agarwal or the Probation Service, at the date of conviction.

126. Exception 2 is not applicable here. In relation to Exception 1, I am satisfied that the appellant has been lawfully resident in the United Kingdom for most of his life, and is socially and culturally integrated. I am also satisfied, on the evidence, that there would be very significant obstacles to his integration in Zimbabwe, given his health and the lack of community or family support for him there.

127. As regards the appellant's capacity for integration in Zimbabwe, I note that he has lived away from his home country, with only two short visits, since he was 8 years old. He is 26 now. For most of his life, save for the three years of his imprisonment and probation licence, the appellant has lived in a household with his family members. He is not working in the United Kingdom: he is not well enough to do so, even with his treatment regime as it is. I accept the submission that given his illness, he will find it difficult to make new friends or find employment in Zimbabwe. I am satisfied that the appellant can bring himself within Exception 1.

128. The question is whether his circumstances are such as to amount to 'very compelling circumstances over and above those described in [Exception 1]'. On the facts of this appeal, I am satisfied that they are. The appellant is barely coping, with all of the support and medication here, and the input of his mother and father. I take judicial notice of the change in circumstances so that Zimbabwe is no longer a red list country, but the appellant has spent almost no time there since he was 8 years old and would not be able to access regular medication or community support, on the evidence. I have found that his grandparents need support themselves and have no experience of dealing with the appellant when he is not well.

129. Supplies of medication and medical staff have deteriorated during the pandemic and the respondent's evidence as to community support is too slight to satisfy me that the appellant would receive the supervision and depot injections he needs to stay as well as he is at present. He is not in particularly good mental health, even with all of that, and has tried to commit suicide as recently as June 2021.

130. The respondent's case comes in the end to this: in 2019, there was one doctor in Harare who said he knows of one nurse who might visit the appellant at home, presumably for a fee. There is no overarching state system of mental health support. The respondent hopes that the appellant's mother would be able to bridge the difficulty in supporting him for a time, with her knowledge of him and her nursing experience and training. However, when she left, nothing like the present regime would be available.

131. As regards Article 3 ECHR, on the particular facts of this appeal, I consider that the *Paposhvili* test is met. The respondent accepts that there would be likely to be a serious and rapid decline in the appellant's mental health in Zimbabwe, causing him intense suffering. That would include a resumption of the louder negative auditory hallucinations which caused him to attempt suicide earlier this year. This time, his mother would not be there to ensure prompt intervention. The risk of irreversible decline and/or death is clear, on the medical evidence and the evidence of the appellant's parents.

132. The appellant's appeal is allowed.

DECISION

133. 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.

The previous decision has been set aside.

I remake the decision by allowing the appellant's appeal.

Signed Judith AJC Gleeson Date: 13 October 2021
Upper Tribunal Judge Gleeson