Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: PA/00128/2019**

THE IMMIGRATION ACTS

Heard at Bradford IAC
On 29 October 2021

Decision & Reasons Promulgated
On 17 November 2021

Before

UPPER TRIBUNAL JUDGE REEDS

Between

O B
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Mr Greer, Counsel instructed on behalf of the Appellant.
For the Respondent: Mr Diwnycz, Senior Presenting Officer

DECISION AND REASONS

Introduction:
Rule 14: The Tribunal Procedure (Upper Tribunal) Rules 2008
I have been asked by the parties to make anonymity direction as part of the factual background of the case involves issues akin to a protection claim. I find that it is appropriate to make the order sought by both parties. Unless and until a tribunal or court directs otherwise, the appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him. This direction applies both to

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the appellant and to the respondent. Failure to comply with this direction could lead to contempt of court proceedings.

Introduction:

1. The hearing before the Upper Tribunal is a resumed hearing following the decision of Upper Tribunal Judge Lane promulgated on 20 November 2020. In that decision UTJ Lane set out his reasons for reaching the conclusion that the decision of the FtTJ (Judge Kelly) (hereinafter referred to as the "FtTJ") involved the making of an error on a point of law, the FtTJ having dismissed the appeal against the decision of the respondent made on the 19 December 2018 refusing his protection and human rights claim.

2. The relevant part of UTJ Lane's decision is replicated below.

"1. The appellant was born on 10 May 1969 and is a male citizen of Ghana. He appealed against a decision of the Secretary of State dated 19 December 2018 refusing his protection and human rights claim. The appellant is HIV positive and has other medical problems. The First-tier Tribunal, in a decision promulgated on 6 September 2019, dismissed the appeal. The appellant now appeals, with permission, to the Upper Tribunal.

2. At the initial hearing by Skype at Bradford on 5 November 2020, I informed the representatives of both parties that I intended to set aside the decision. I also granted the application made by the appellant to amend the grounds of appeal in accordance with the text set out in the further submissions filed by Mr Greer, counsel for the appellant. I shall now briefly give my reasons for setting aside the decision.

3. There are three grounds of appeal. Ground 2 challenges the decision on the basis that the judge's finding [26] that, although the appellant has significant mobility problems, he is not too ill to undertake sedentary work whilst his condition is controlled by an appropriate treatment regime was at odds with the medical expert upon whose evidence the appellant relies. I find that this ground has no merit. The medical expert refers to the appellant's inability to work in the United Kingdom on account of his asylum status which is obviously not a factor which would apply in Ghana. The expert also refers to the appellant being unable to work such that his pay would provide for private healthcare insurance. Neither of those observations of the expert detract or undermine the judge's finding that the appellant would be able to undertake 'sedentary work.' I am satisfied that the judges reached finding on this point, which was available to him on the evidence, including that of the appellant's medical expert. Ground 3 challenges the judge's finding at [28] rejecting the opinion of another expert, Professor Lawrence, the appellant would suffer discrimination in Ghana on account of his epilepsy. The judge found that, because suitable anti-convulsant drugs would be available to the appellant in Ghana, his epileptic condition would not manifest itself to others. The appellant contends that he would have to approach a doctor for a prescription for such anti-convulsant drugs, thereby disclosing his condition. I do not find it at all likely that the appellant would suffer serious discrimination from any medical practitioner who

might prescribe drugs to him; it is clear from all the background material that any discrimination would arise within the wider community and Judge Kelly's finding that, if he were to receive the necessary drugs, the appellant's condition would not be manifest in that wider community is clearly sound into law.

4. Ground 1, however, does have merit. The appellant asserts that the judge misunderstood medical evidence. At [22], Judge Kelly found that the appellant had failed to identify the source of information to support the assertion that complex the HIV medication which the appellant requires to treat his condition is not available in Ghana. Further, there was no basis for the judge's finding that the appellant failed to explain why HIV drugs, which are available in Ghana, would be unsuitable for his treatment. The medical expert did in his report explain why the medication available in Ghana would be unsuitable, namely because of the interactions between the available HIV medication and other drugs which the appellant takes for other medical conditions. Those interactions are likely, in the opinion of the expert, to cause renal and cardiovascular toxicities. The representatives of both parties before the Upper Tribunal acknowledged that the judge had made a mistake in fact by finding that the appellant had not identified 'the source of the information that it is said that support the assertions' that suitable drugs were not available in Ghana'. As a consequence of his misunderstanding of the evidence, the judge fell into error. His subsequent finding that 'if the available drugs in Ghana are merely less effective than those prescribed for him United Kingdom, this would not necessarily mean that they were incapable of preventing a rapid decline of his health leading to intense suffering or a significant shortening of his life expectancy' is unsound because it is based upon misreading of the evidence. For that finding to stand, it would have been necessary for the judge to have explained why he placed little or no weight upon the medical expert's opinion regarding the likely toxic interactions between the drugs. Without that finding, it is not possible to determine this appeal subject to the law as articulated in *AM (Zimbabwe)* [2020] UKSC 17."

3. UTJ Lane therefore set aside the decision of the FtTJ and for it to be remade in the Upper Tribunal having given directions to the parties concerning the provision of any further evidence relied upon for the resumed hearing.

4. In the light of the delay between the promulgation of the decision and identifying a suitable date for the hearing, a transfer order has been made to enable a different UTJ to hear the remaking of the appeal.

5. This decision follows a remote hearing which has been consented to and no objection has been made by the parties. The form of remote hearing was a video hearing by way of Microsoft teams. It was accepted by all parties that it was not necessary for a face to face haring and that all issues could be fairly determined in a remote hearing as set out in the directions of UTJ Lane.

6. At the hearing before the Upper Tribunal the appellant was represented by Mr Greer who represented the appellant before the FtTJ and UTJ Lane. The respondent represented by Mr Diwnycz, senior presenting officer. The appellant

was also present and was provided with the assistance of the court interpreter, who I am satisfied was able to understand the appellant and vice versa and was able to translate the proceedings for the appellant.

7. I am grateful for the helpful and clear submissions that I have heard from both advocates.

8. By way of a preliminary issue, there is an application for an extension of time to file evidence. At [5] of UTJ Lane's order of 27th November 2020, the Appellant was directed to file and serve additional evidence no less than 28 days before the resumed hearing. In fact, the Appellant filed and served his Consolidated bundle on 22nd October 2021, that is 7 days before the hearing. The appellant applies for this evidence to be admitted out of time.

9. The reason for the delay in filing and serving the evidence is that the most recent medical note from the Appellant's treating doctor is dated 20th October 2021 and therefore became available very shortly prior to the hearing.

10. It is submitted that it is in the interests of justice to admit this evidence for the following reasons. Firstly, the material concluded within the consolidated bundle is of significant probative value in respect of the issues in dispute between the parties. The matter cannot be determined justly without up-to-date evidence of the Appellant's condition and the availability of medication in the Appellant's country of origin. Secondly, the Appellant took all reasonable steps to make contact with the Senior Presenting Officer with conduct of the matter such as to minimise the prejudice caused to the Respondent by the late service of this evidence. In the circumstances, Mr Greer submits that the Appellant's consolidated bundle ought to be admitted.

11. Mr Diwnycz on behalf of the respondent confirmed that he had received the bundle last week and that he did not object to the evidence as filed. Consequently as there is no objection to the filing of the evidence I admit that evidence.

The background:

12. The appellant is a national of Ghana. The factual background does not seem to be in dispute. The appellant entered the United Kingdom in Ghana on 8 September 2012 in order to look for work. He was refused leave to enter but did not return to Ghana. He was diagnosed with HIV in November 2015 and claimed asylum on 20 December 2016. He was interviewed about his claim on 8 June 2017, and it was refused on 19 July 2018. That decision was withdrawn in September 2018 pending production of further medical evidence. The appellant's claim was refused again on 19 December 2018, and he gave a notice of appeal against that decision on 2 January 2019.

13. The respondent refused his claim in a decision letter dated 19 December 2018.

14. The relevant parts of the decision are set out at paragraphs 59 – 95. The respondent accepted that the appellant had a complex medical condition by reason of his HIV. The respondent accepted the evidence that the appellant had received medical treatment for those conditions since December 2015 and in accordance with the medical evidence provided.

15. At paragraphs 60 – 65 the respondent set out a summary of the medical evidence that had been provided to her (a letter dated 4/10/2018). It set out that the appellant had been diagnosed with HIV in November 2015, seizures controlled on Levetiracetam, right proximal DVT completed 6 months Tinzaparin. There were previous infections including refractory Mycobacterium Avium Intracellular (MIA) and oral and oesophageal candidiasis-suppressed on Fluconazole.

16. The current HIV medications commenced on 3110 2017 were described as Descovy 25 (Tenofovir Alafenamide Emtricitabine, Raltegravir, Co-Trimoxazole and Acyclovir. Other medications were Amlodipine, Ad-CAl D3 2 tablets, Ranitidine, Senna, Thiamine, Forceval, Azathiprine, Budesonide.

17. The respondent concluded that the evidence provided did not indicate that his medical condition was at such a critical stage that it would be inhumane to remove the appellant. Whilst it was noted that the medical evidence stated that Descovy 25 is unavailable in Ghana, there were a range of other treatments for HIV available in Ghana.

18. It was further considered that whilst the appellant suffered from several conditions which could be considered to fall under Article 3 (medical) and Article 8 (physical and moral integrity) of the ECHR, when assessing the medical positions individually it was considered that although treatment is substandard to UK NHS treatment, there is treatment available in Ghana (at paragraph [69]).

19. The respondent stated that Ghana had a public health service and that external sources also stated that they were teaching, private and mission hospitals which in addition to the public health service also provided treatment. There was also a medical insurance system which enabled people to access healthcare.

20. It was noted that the appellant had suffered from HIV for which he was taking Descovy 25 but the country of origin (COI response; Ghana: medical: disability 23/02/2018 stated a number of treatment sites is increasing across Ghana making treatment more accessible).

21. The same source also stated there were a number of medications available and that the medication the appellant was currently taking Descovy 25 is available however not in the same formulation. The decision letter cited the COI response as to the following medication being available:

    "information obtained from MedCOI sources indicated the availability in the country the following (at least from largely public facilities in Accra):-

in and outpatient treatment and follow-up by HIV specialists: Abacavir, Zidovudine, Atazanavir, Efavirenz, Emtricitabine, Nevirapine, Ritonavir, Tenofovir Disoproxil, Tenofovir Alafenamide, Combivir, Atripla, Descovy, Kaletra and Truvada.

Not available (currently): Dolutegravir, Elvitegravir, Fosamprenavir, Rilpiravine, Epsicom Kivexa, Genvoya, Rezolta, Triumeq, Trizivir and Cobistat (1.1.2).

22. It was also noted that the government was active in ensuring the treatment for HIV is more widely available as stated by the government of Ghana.

23. The respondent also noted that there were non-governmental organisations (NGO's) and community-based organisations working together to provide support for those with HIV as stated by the Ghana AIDS commission.

24. The respondent therefore concluded that even though HIV treatment may not be to the standard of the treatment available in the UK, there would be various organisations providing a range of treatment. He would also be able to obtain treatment for opportunistic infections.

25. The respondent concluded that there was a functioning healthcare system in Ghana which would be able to provide adequate treatment even if the appellant was required to pay for it and that it would not be at the level he had experienced within the UK. As to his ability to work, having taken into account the medical evidence, it was considered not to be a barrier to return to Ghana and that he would be able to secure employment to pay for his healthcare.

26. The respondent concluded that it was not accepted that his removal from the United Kingdom reached a high threshold of severity necessary to breach Article 3 (medical claim) and Article 8 (physical and moral integrity) of the ECHR based on his medical condition.

27. The appellant's claim was therefore refused.

28. On appeal before the FtTJ, the appellant's claim was summarised between paragraphs 4 – 6. The appellant's HIV is currently being managed by a combination of medicines including antiretroviral drugs, provided to him by the UK NHS. He had been additionally prescribed the drug Levetiracetam in order to control his epileptic seizures. His only surviving relative is his mother although she resides in Ghana she is now aged 80 years and is unwell.

29. Whilst there is a national health insurance scheme in Ghana, the appellant and paid into it. He could not afford to pay for treatment privately because he is too ill to work and would have no other source of income. His condition would therefore deteriorate rapidly on return to Ghana, and he would die very soon thereafter.

30. The respondent's case was summarised between paragraphs 7 – 8 and relied upon the decision letter summarised above.

31. Having considered the evidence including the oral testimony from the appellant and the medical evidence submitted on the appellant's behalf, the FtTJ concluded that he was not satisfied that nothing less than the precise combination of drugs that the appellant was being prescribed in the UK would suffice to avoid a rapid deterioration in his health, leading to intense suffering or significant shortening of life expectancy in the medical evidence. The FtTJ was therefore not satisfied that the appellant's removal would amount to a breach of Article 3 of the ECHR (at [27]. Additionally, the judge was not satisfied of the unavailability of suitable anticonvulsants drugs in Ghana and that he was not satisfied that there was a real risk that the appellant's epilepsy would manifest itself to others and therefore would be either discriminated against or ill-treated by members of Ghanaian society (at [28]).

32. He concluded in relation to Article 8 that the appellant's mother would be able to provide him with a home on return and that he is fluent speaker of the Twi language therefore was not satisfied that there were very significant obstacles to the appellant's reintegration in Ghana (paragraph 276 ADE (1) (vi)) and had failed to demonstrate that his removal would be an unlawful interference with his right to respect for private life under Article 8 of the ECHR (at [29]). He therefore dismissed the appeal.

33. As set out above following an application for permission to appeal that decision and permission having been granted, UTJ Lane reached the conclusion that the decision involve the making of an error on a point of law and set aside the decision for it to be remade in the Upper Tribunal.

<u>The evidence:</u>

34. The appellant provided a bundle of documents which included the documents that had been before the First-tier Tribunal and also updating medical evidence and background country materials including a report from a country expert.

35. The respondent did not provide any further material since the decision letter as summarised above.

36. Mr Greer indicated that there was a witness statement from the appellant but that he would not be giving oral evidence to the Tribunal. Mr Diwnycz confirmed there was no challenge to his evidence.

<u>The submissions:</u>

37. Mr Greer on behalf of the appellant set out his written submission in a skeleton argument. They can be summarised as follows.

38. As to Article 3_and the "prima facie case" he submits that the Secretary of State appears to have conceded that the evidence adduced by the Appellant was sufficient to create a prima facie case that the Appellant's removal would be contrary to Article 3 ECHR. At Paragraph 69 of the Reasons for Refusal Letter she states:

> *Even though it is considered you suffer from several conditions which cumulatively could be considered to fall under Article 3 (medical rights) and Article 8 (Physical and moral integrity) of the ECHR. When assessing the medical conditions individually it is considered that although treatment is substandard to the UK NHS treatment, there is treatment available in Ghana.*

39. Whether or not the Respondent seeks to apply to withdraw that concession (and there is no indication to suggest that she shall make such an application), the Appellant has adduced before the tribunal evidence capable of demonstrating that there are substantial grounds for believing that, if removed, he would be exposed to a real risk of subjection to treatment contrary to Article 3.

40. Mr Greer relies upon the report dated 20th October 2021, from the Consultant Teaching Hospitals NHS Trust Dr L who states the following conclusion at, *Page 15)*:

> *If (the appellant) was to stop taking his current HIV medications, I think his health would decline very rapidly and he would likely die within a year. His antiretroviral therapy is not first-line treatment, and this has been escalated to the current HIV treatment medication due to drug side-effects which caused renal impairment with his earlier treatment regimens. These drugs, I believe, are not available in Ghana, however, older more generic versions are which unfortunately are not possible for (the appellant) to take due to the side-effects and renal impairment they cause.*
>
> *If (the appellant) was to stop taking this treatment, I think he would likely survive less than 12 months in Ghana. I think he would likely then succumb to an opportunistic infection.*

41. Mr Greer submits that the Respondent has called no case specific medical evidence to undermine Dr L's opinion. Therefore, this expert evidence appears to be unchallenged. The serious, rapid and irreversible decline in the Appellant's health prognosticated by Dr L is of such severity as to potentially breach Article 3.

42. He further submits that the Appellant has adduced evidence capable of demonstrating that suitable treatment would not be available to him in Ghana, relying on the recent report of Dr L at Page 14AB):

"3) (the appellant) continues taking medication in the form of Descovy (co-formulated Emtricitabine, Tenofovir Alafenamide 200/25 mg one tablet daily) together with Raltegravir 400 mg bd - this is essential for his HIV. These drugs are not available in Ghana, and due to his impaired renal function, if he were to take the more generic treatments that are available in Ghana, he would likely suffer with renal toxicity so these agents would not be suitable for (the appellant).

Similarly his autoimmune liver disease is well-controlled on Azathioprine medication, which is not available in Ghana.
The medication available in Ghana is available in the Home Office document: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812958/Ghana_-_Medical_and_Healthcare_-_CPIN_-_v1.0__GOV.UK_.pdf"

43. Therefore it is submitted that the medication the Respondent claims would be available in Ghana would be unsuitable for the Appellant as he would likely suffer with renal toxicity. This evidence is sufficient to make a prima facie case under [23(a)] of AM Zimbabwe.

44. As to the Respondent's procedural obligations, Mr Greer submits that the Respondent has not called any evidence to dispel the doubts raised by this evidence. The Respondent has not addressed reports of reputable organisations about treatment in Ghana (AM Zimbabwe [23(b)])

45. Furthermore, the Respondent has not verified on a case-by-case basis whether the care generally available in Ghana is in practice sufficient to prevent the applicant's exposure to treatment contrary to Article 3. The evidence before the tribunal demonstrates that it is not (AM Zimbabwe [23(c)])

46. The Respondent has not considered the accessibility of the treatment to the Appellant (AM Zimbabwe [23(d)]

47. The Respondent has not obtained an individual assurance from Ghana that appropriate treatment would be available and accessible to the Appellant (AM Zimbabwe [23(e)].

48. Rather, in response to the Appellant's *prima facie* case, the Secretary of State, in her Reasons for Refusal letter, has advanced the positive case that a number of medications are available in Ghana. The Secretary of State has made no specific assertion in respect of the suitability of that treatment for the Appellant, only that it is available (*Reasons for Refusal Letter, Paragraph 69 – 88*). The Secretary of State suggests that a different formulation of the Appellant's medication is available in Ghana, but has made no specific claim, and has called no medical evidence, in respect of its suitability (*Reasons for Refusal Letter, Paragraph 73*)

49. In contrast he submits that Dr L specifically responded to the Secretary of State's assertions in her letter of 1st February 2019, at Page 5 of the Appellant's bundle, in the following terms:

    Re: Paragraphs 68 and 73

    Treatment options available for HIV in Ghana are not suitable for (the appellant) because of the drug-drug interactions with his other medications and their renal and cardiovascular toxicities. Have again confirmed that Descovy (tenofovir alafenamide/emtricitabine) manufactured by Gilead is not available in Ghana. Raltegravir and a similar drug dolutgravir are also not available in Ghana. (emphasis added).

50. That letter goes on to state:

    Re Paragraph 76

    As (the appellant) needs complex HIV medication that is not available in Ghana his health is likely to suffer if he is switched to alternative regimens due to their toxicities and potential drug interactions.

51. The Respondent has adduced no medical evidence to dispute Dr L's evidence in respect of the suitability of the medication that the Secretary of State claims to be available in Ghana. Nor has the Secretary of State adduced any evidence to demonstrate that the 2 alternative, suitable drugs mentioned by Dr L in her most recent letter would be available to the Appellant in Ghana.

52. Mr Greer therefore submits that in the light of the evidence the Appellant's claim under Article 3 ECHR is entitled to succeed.

53. In the alternative and by reference to Article 8, he submits that the background evidence before the tribunal establishes that an individual in the Appellant's circumstances is likely to face hostility and discrimination on account of his HIV status and perceived mental disability (Appellant's Bundle, Page 25, Paragraph 52 – 82. Page 36, Paragraph 19 – 27, 31 – 32). He will therefore face very significant obstacles to his integration upon return to Ghana.

54. In his oral submissions Mr Greer reminded the tribunal of the decision in AM(Zimbabwe) and the test that the tribunal should apply. He submitted that the answer to the questions firstly, whether the medical treatment would be sufficient to demonstrate a breach of Article 3 and secondly whether the appellant had provided an arguable case that treatment was not available to him in Ghana, was answered by the most recent medical report dated 21 October 2021. In particular he submitted paragraphs 5 and 6 of that report demonstrated that the appellant's life expectancy would be reduced and thus it amounted to a "serious and rapid decline" in his health in terms of the Paposhvili test and AM (Zimbabwe).

55. Mr Greer submitted that the relevant consultant had taken into account the respondents CPIN as to what drugs would be available but due to the complexity of the appellant's condition the drugs that are available and set out in the respondent's evidence are unsuitable for the reasons set out at paragraph 3 of the doctors report. Consequently the medication required for the appellant is not available in Ghana and if he were to take what is available, the appellant would suffer from renal toxicity. Thus he submitted the respondent's own CPIN taken in conjunction with the medical evidence demonstrated that the appellant's case is made out.

56. When looking at the next stage, the burden shifted to the respondent to dispel the doubts raised by the evidence. The appellant had answered the respondent's evidence and the generic evidence has been rebutted.

57. Mr Greer submitted that the procedural obligations incumbent on the Secretary of State had not been met in the light of the consultants letter. It would have been open to the respondent to provide evidence to demonstrate that medical treatment would be available or in the alternative could instruct a different consultant to provide medical evidence to say that it would be open to the appellant to take other medication. However the Secretary of State has done neither and thus the limbs of the procedural tests are also met by the appellant.

58. As to the final option of an individual assurance, this has not been sought.

59. For those reasons, Mr Greer submitted that the appellant had established that he had met the threshold to demonstrate a breach of Article 3 of the ECHR on medical grounds applying the decision of AM (Zimbabwe).

60. In the alternative he submitted, there was no suggestion of any criminality on the appellant's behalf, and he would fall within the category of a "ordinary overstayer". There was nothing in his immigration history that was adverse to him and therefore if the appellant could establish the requirements of the rules, he would succeed on that basis.

61. Mr Greer relied upon his skeleton argument as summarised above. One of the factors related to the background material as to the position of those who suffer discrimination and stigma as a result of their medical condition. Thus he submitted the appellant would also succeed in establish that there were "very significant obstacles" to his integration to Ghana.

62. On behalf of the respondent Mr Diwnycz informed the court that there was no challenge to the medical evidence provided on behalf of the appellant and that respondent had not filed any further evidence. There had been no access to the MedCOI resources, and he accepted that the weight of the medical evidence weighed in the appellant's favour, and he could offer no counter argument.

63. At the conclusion of the submissions I reserved my decision. I am grateful to the careful submissions made by each of the advocates.

The legal principles:

64. The relevant legal principles are set out in the written skeleton argument submitted by Mr Greer and can be summarised as follows.

65. In AM (Zimbabwe) (Appellant) v SSHD (Respondent) [2020] UKSC 17 the Supreme Court considered and endorsed the judgment of the Grand Chamber of the European Court of Human Rights (the ECtHR) in Paposhvili v Belgium [2017] Imm AR 867 which gave an expanded interpretation of Article 3 ECHR in the context of medical treatment cases.

66. The appellant in AM (Zimbabwe) was settled in the UK when a deportation order was made against him because of very serious criminal offences. He was also HIV+ and claimed that he would be unable to access the appropriate antiretroviral therapy in Zimbabwe which would cause him to become prey to opportunistic infections and which, if untreated, would lead to his death.

67. The Supreme Court, having analysed Paposhvili and several other judgments, concluded that the Grand Chamber's pronouncement about the procedural requirements of Article 3 were not merely clarificatory and that the Grand Chamber had modified the earlier approach in N v United Kingdom (2008) 47 EHRR 39.

68. The formula posited in Paposhvili was that there must be a real risk of a person:

"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".

69. At paragraph [23] the Supreme Court stated:

"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;

(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;

(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;

(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

(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."

70. The correct approach was further clarified at [32] as follows:

> "...The threshold, set out in para 23(a) above, is for the applicant to adduce evidence "capable of demonstrating that there are substantial grounds for believing" that Article 3 would be violated. It may make formidable intellectual demands on decision-makers who conclude that the evidence does not establish "substantial grounds" to have to proceed to consider whether nevertheless it is "capable of demonstrating" them. But, irrespective of the perhaps unnecessary complexity of the test, let no one imagine that it represents an undemanding threshold for an applicant to cross. For the requisite capacity of the evidence adduced by the applicant is to demonstrate "substantial" grounds for believing that it is a "very exceptional" case because of a "real" risk of subjection to "inhuman" treatment. All three parties accept that Sales LJ was correct, in para 16, to describe the threshold as an obligation on an applicant to raise a "prima facie case" of potential infringement of Article 3. This means a case which, if not challenged or countered, would establish the infringement: see para 112 of a useful analysis in the Determination of the President of the Upper Tribunal and two of its senior judges in AXB v Secretary of State for the Home Department [2019] UKUT 397 (IAC)."

71. Additionally the decision in Savran v Denmark (57467/15) also makes it clear that the authorities must consider the extent to which the individual in question will *actually* have access to this care and these facilities in the receiving State.

72. Therefore AM (Zimbabwe) marks an important departure from the previous position pursuant to D v UK (1997) EHRR 423 and N v UK (2008) 47 EHRR 39. The proper test is now whether return would lead " *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*". That is to be read together with the second category, beyond deathbed cases, identified in Paposhvili v Belgium [2017] Imm AR 867 namely those which " *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."

Analysis of the evidence:

73. In reaching my assessment, I bear in mind that the burden is on the appellant to establish his claim. For Article 3, he must establish that there are substantial grounds for believing that there is a real risk of serious harm on return. The burden and standard of proof applies to the factual matters in issue in this appeal.

74. The appellant's bundle contains 4 medical reports from the appellant's consultant, and they are dated 1/2/2019 (p.4 – 6 AB), 5/9/2018 (p.7 – 11 AB) 1/10/2018 (p.12 – 13 AB and 21/10/2021 (p14 – 15 AB).

75. There is no challenge to the medical evidence in behalf of the respondent.

76. The most recent report is set out at pages 14-15 AB and is dated 21 October 2021. It is stated that the appellant's general health is stable at present; he has a suppressed HIV viral load and CD4 count above 200 cells/ul. His current medical condition is that he is stable with well-controlled HIV with a suppressed HIV viral load. His autoimmune liver disease is also stable with normalisation of his liver function test on Azathioprine treatment – he is under regular hepatology follow-up for this.

77. The report notes that he has ongoing peripheral neuropathy-type pain, and impaired renal function with an elevated protein: creatinine ratio. He has ongoing bilateral knee pain and has suffered from bilateral knee effusions (swelling of both knees which has required hospitalisation for symptomatic relief). He has had bladder warts treated previously by urology and deep-vein thrombosis of his right leg in the past for which he successfully completed therapy. He remains limited by his severe knee pain which causes problems in mobilisation, climbing stairs, otherwise his condition is stable.

78. In terms of medication, it is confirmed that he continues to take medication in the form of Descovy (co-formulated Emtricitabine, Tenofovir Alafenamide 200/25 mg 1 tablet daily) together with Raltegravir 400 mg BD which is essential for his HIV.

79. The doctor states, "these drugs are not available in Ghana, and due to his impaired renal function, if he were to take the more generic treatments that are available in Ghana, he would likely suffer with renal toxicity so these agents would not be suitable.. Similarly his autoimmune liver diseases well-controlled on Azathioprine medication which is not available in Ghana".

80. As to employment, the doctor concluded that he would be able to take some form of employment, but he is not suitable for manual employment due to the problems

of his severe knee pain and arthralgia and being D condition from the physical activity point of view due to the coronavirus pandemic.

81. The Dr concludes at paragraph 5 as follows:

" HIV therapy is essential for (the appellant's) ongoing health and well-being. If he stopped HIV treatment, it is likely that his CD4 count in his immune system would fall rapidly and he would be at risk of developing the life threatening a typical mycobacterial infection and other opportunistic infections. Previously he had a prolonged course of infection with atypical mycobacteria for which he required a protracted course of treatment and adjunctive therapy whilst an inpatient. It is likely that this would not be available to him in Ghana. In addition if his Azathioprine was stopped, it is likely that he would suffer a deterioration of his liver function, which also might be life threatening. The timescale of this is difficult to predict, but certainly from the HIV point of view I suspect if his HIV treatment was stopped, I would predict that he will become unwell due to secondary opportunistic infection within 6 to 12 months of his return to Ghana without his current treatments".

82. At paragraph 6 the doctor states that the appellant is not taking Levetiracetam, and that the doctor considered that the instructions may mean his "autoimmune hepatitis and Azathioprine ". The doctor stated that this is not available in Ghana and steroids would not be suitable as he became diabetic and had a reaction to standard Prednisolone, which would be available.

83. In conclusion it was stated that:

"If (the appellant) was to stop taking his current HIV medications, I think his health would decline very rapidly and that he would likely die within a year. His antiretroviral therapy is not first-line treatment, and this has been escalated to the current HIV treatment medication due to drug side effects which caused renal impairment with his earlier treatment regimens. These drugs, I believe, are not available in Ghana, however, all the more generic versions are which unfortunately not possible for (the appellant) to take due to the side effects and renal impairment they cause. If (the appellant) was to stop taking this treatment, I think he would likely survive less than 12 months in Ghana. I think you would likely then succumbed to an opportunistic infection."

84. The appellant's bundle also contains a report from Professor Benjamin Lawrence dated May 19, 2019. There has been no challenge to those reports before this tribunal. The Supreme Court observed in *Kennedy v. Cordia (Services) LLP* [2016] UKSC 6, [2016] 1 WLR 597, at [41], that an expert in the social and political conditions existing in a foreign country who gives evidence to an immigration judge is giving expert evidence of fact. In considering whether the witness is an 'expert', the Supreme Court, at [43], approved the approach adopted in the South Australian case of *R. v. Bonython* (1984) 38 SASR 45, per King CJ at pp 46-47:

> 'Before admitting the opinion of a witness into evidence as expert testimony, the judge must consider and decide two questions. The first is whether the subject matter of the opinion falls within the class of subjects

> upon which expert testimony is permissible. This first question may be divided into two parts: (a) whether the subject matter of the opinion is such that a person without instruction or experience in the area of knowledge or human experience would be able to form a sound judgment on the matter without the assistance of witnesses possessing special knowledge or experience in the area, and (b) whether the subject matter of the opinion forms part of a body of knowledge or experience which is sufficiently organized or recognized to be accepted as a reliable body of knowledge or experience, a special acquaintance with which by the witness would render his opinion of assistance to the court. The second question is whether the witness has acquired by study or experience sufficient knowledge of the subject to render his opinion of value in resolving the issues before the court.'

85. I am satisfied as to the first question that the Tribunal would properly be aided by expert evidence concerning Ghana. I also accept that Professor Lawrence has the necessary knowledge and experience to assist the Tribunal. The Supreme Court held, at [50], that an expert witness must demonstrate to the Tribunal that they have relevant knowledge and experience to give either factual evidence, which is not based exclusively on personal observation or sensation, or opinion evidence. Where the expert witness establishes such knowledge and experience, they can draw on the general body of knowledge and understanding of the relevant expertise. There has been no challenge to his evidence and having read his reports in the context of the country materials set out in the appellant's bundle, which include the US State Department report, a more updated CPIN and human rights watch report, the sources relied upon reach similar conclusions.

86. Professor Lawrence concludes in that report that the HIV medication the appellant requires is not available. He further concludes that the respondent's information is factually incorrect, and that HIV/AIDS care is not covered under the Ghanaian National Health Service despite what is stated at paragraph 70 of the decision letter. Provision is the remit of the Ghanaian AIDS commission.

87. An addendum to his report is also set out in the bundle (p34). In that report he confirms the earlier report of 2019 and in the summary and conclusions and recommendations set out at page 38, he confirms that people living with HIV/AIDS suffer extreme discrimination and prejudice in Ghana, relying on the earlier sections of his 2019 report and his later report at page 35, where he set out the background material in support of his conclusions. In the latest report, and by reference to the country materials, he concludes that the incidence of HIV-related stigma remains high in Ghana. Considerable portions of PLWHA's have experienced violence and the threat of violence, ostracism, loss of employment, housing, denial of essential health and social services because of their HIV status. At paragraph 12 reference is made to HIV being among the most "stigmatised conditions in the world and also known to erode the confidence, social networks,

and status of sufferers leading to isolation, concealment, and treatment failure resulting from a high incidence of nonadherence to medications."

88. As I have set out above, there has been no challenge to the medical evidence by the respondent. Nor has there been any further evidence adduced on behalf of the respondent. Whilst in the decision letter of 2018 reference had been made to the type of medication available and that the appellant could take a different type of medication, based on the medical evidence before this Tribunal, it plainly sets out that the generic versions available would lead to side effects and renal impairment and lead to a rapid decline in his health. Additionally, the medical report is clear as to the consequences for the appellant should his treatment cease in terms of impairment of his life expectancy.

89. There is an obligation upon the appellant in this matter to raise a *prima facie* case of potential infringement of his Article 3 rights before evidential obligations are placed upon the respondent. As to a *prima facie* case, the Court in Paposhvili confirmed at paragraph [186] as follows:

> '186. In the context of these procedures, it is for the applicants to adduce evidence capable of demonstrating that there are substantial grounds for believing that, if the measure complained of were to be implemented, they would be exposed to a real risk of being subjected to treatment contrary to Article 3 (see *Saadi,* cited above, Â§ 129, and *F.G. v. Sweden,* cited above, Â§ 120). In this connection it should be observed that a certain degree of speculation is inherent in the preventive purpose of Article 3 and that it is not a matter of requiring the persons concerned to provide clear proof of their claim that they would be exposed to proscribed treatment (see, in particular, *Trabelsi v. Belgium*, no. 140/10, Â§ 130, ECHR 2014 (extracts)).'

90. In light of the medical evidence and applying the Paposhvili test as set out in the decision of AM (Zimbabwe) and as summarised above, I am satisfied that the appellant has presented evidence that in my view is sufficient and capable of demonstrating that there are substantial grounds for believing that the appellant could face a real risk of being exposed to a serious, rapid and irreversible decline to his state of health resulting in intense suffering or to a significant reduction of life expectancy on account of the unavailability of the appropriate medication and specialised treatment and monitoring required for this appellant's particular care needs.

91. As I have stated above, there has been no challenge the medical evidence and in particular the report of Dr L. Nor is there any challenge to the country expert report of Professor Lawrence. Therefore in answer to the first question posed, in my judgement is that the medical evidence taken together with the country materials which concern the lack of medication and treatment available for the appellant, is plainly sufficient to meet the Article 3 threshold and that if returned to Ghana where his medical treatment regime medication is not available he would suffer a rapid decline in his state of health.

92. I now turn to the next question identified by Mr Greer and to consider whether the respondent has dispersed any doubts raised by the evidence adduced on behalf of the appellant?

93. Upon the appellant presenting evidence to the required standard, the respondent can seek to counter it in the manner outlined by the Strasbourg court in Paposhvili, at [187] - [191]. Paragraph 187 states as follows:

> "187. Where such evidence is adduced, it is for the authorities of the returning State, in the context of domestic procedures, to dispel any doubts raised by it (see *Saadi*, cited above, Â§ 129, and *F.G. v. Sweden*, cited above, Â§ 120). The risk alleged must be subjected to close scrutiny (see *Saadi*, cited above, Â§ 128; *Sufi and Elmi v. the United Kingdom*, nos. 8319/07 and 11449/07, Â§ 214, 28 June 2011; *Hirsi Jamaa and Others*, cited above, Â§ 116; and *Tarakhel*, cited above, Â§ 104) in the course of which the authorities in the returning State must consider the foreseeable consequences of removal for the individual concerned in the receiving State, in the light of the general situation there and the individual's personal circumstances (see Vilvarajah and Others, cited above, Â§ 108; *El-Masri*, cited above, Â§ 213; and *Tarakhel*, cited above, Â§ 105). The assessment of the risk as defined above (see paragraphs 183-84) must therefore take into consideration general sources such as reports of the World Health Organisation or of reputable non-governmental organisations and the medical certificates concerning the person in question".

94. In this context, has the respondent done enough to counter the evidence and subject the alleged risk to this appellant to close scrutiny? In other words, has a respondent verified on a case by case basis that the care generally available in Ghana is in practice sufficient to prevent the appellant's exposure to treatment contrary to Article 3?

95. As Mr Greer submitted, the respondent has not chosen to produce any evidence in respect of enquiries she has made as to the availability of the relevant medication identified for the appellant in the medical evidence. The earlier medical evidence in the bundle that concerns the appellant's care needs has been in existence since 2018 – 2020 and no evidence has been provided to counter this or to dispel any doubts by means of any enquiries or any background material. At best the respondent relied on an outdated CPIN in the decision letter which plainly does not take account of the medical evidence and the particular care needs identified in the later reports. No other evidence has been filed by the respondent since the decision letter in 2018. Whilst the decision letter was written before the guidance given in the decision of AM (Zimbabwe), there has been no attempt to provide an amended decision letter since the decision of UTJ Lane setting aside the decision in November 2020.

96. In default of satisfactory evidence concerning the returning state, the respondent is procedurally required to obtain an individual assurance as to the appropriate and accessible treatment for the appellant. Lord Wilson, with whom Lady Hale, Lady Black, Lady Arden and Lord Kitchin agreed, held in AM (Zimbabwe), at paragraph [33] as follows:

'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.'

97. Thus the Supreme Court in AM (Zimbabwe) at paragraph 33 made the point that the returning state is better able to collect evidence about the availability and the accessibility of any suitable treatment in the receiving state. In this appeal, no individual assurance has been obtained on behalf of the respondent that such appropriate treatment would be available or accessible for this appellant in Ghana.

98. Having considered the relevant legal test and the material provided before this Tribunal, I am satisfied that on the evidence available to me that the medical care available for this particular appellant in Ghana and in the light of his own particular care medical needs is not in practice sufficient to prevent a breach of Article 3 of the ECHR. In my judgement the evidence crosses the threshold necessary to demonstrate that the appellant would be exposed to treatment contrary to Article 3 of the ECHR.

99. It therefore follows that this would result in a breach of the U.K.'s obligations under the Human Rights Act 1998.

100. In the alternative, I have considered the appellant's claim in the context of the relevant Immigration Rules and in particular paragraph 276ADE (1) (vi) and the issue as to whether there would be "very significant obstacles" to the appellant's integration to Ghana.

101. Paragraph 276ADE(1)(vi) of the immigration rules states;

(1). The requirements to be met by an applicant for leave to remain on the grounds of private life in the UK are that at the date of application, the applicant:

(vi) subject to sub-paragraph (2), is aged 18 years or above, has lived continuously in the UK for less than 20 years (discounting any period of imprisonment) but there would be very significant obstacles to the applicant's integration into the country to which he would have to go if required to leave the UK.

102. There is no dispute that the appellant is able to speak the language of Ghana, Twi, and that prior to entering the United Kingdom he had lived in Ghana for his formative years. He also has his mother, aged 80, living in Ghana. In the light of the medical evidence relating to his medical condition and his health needs which are such to form an integral part of his private life (his physical and moral integrity), the evidence demonstrates that he would not be able to obtain the appropriate medication required for his condition. I rely on the factual findings set out above in this respect which are not subject of any challenge.

103. I am also not satisfied that he would be able to obtain employment in Ghana to provide him with any means of support to access medication, even if available and the generic medication did not lead to any adverse effects to his health. The medical evidence is that he continues to have knee pain and HIV-related neuropathy which makes it difficult for him to do any form of manual labour. His previous employment history was as a mechanic. Also any type of work which involved in meeting people would potentially put him at an increased risk of opportunistic infections. Even if the appellant would be able to undertake some form of employment, I take into account that he has had no work history in the last 10 years and thus has had no recent employment history or experience.

104. Furthermore in assessing the likelihood of being self-supporting, I take into account the background country evidence which has not been challenged by the respondent. The general thrust of that background country material relates to the social stigma and discrimination of those suffering from HIV/Aids and that this remains a problem in Ghana where they face discrimination in many areas of life including employment. That is also set out in the CPIN September 2020 version 1.0 at section 17 (citing 7.2.5 of the US State Department report). Whilst the law penalises discrimination against a person affected by HIV/AIDS by imposition of substantial fines, imprisonment of 18 months to 3 years or both, and the law contains provisions to protect their rights including rights to employment, in practice there remains a high level of discrimination and stigma (I refer to the US State Department report 2021; page 81 AB). The government is described as not effectively enforcing the prohibition on discrimination in employment (page 82).

105. The phrase "very significant" connotes an "elevated" threshold, and as Underhill LJ noted in Parveen v SSHD, that test will not be met by "mere inconvenience or upheaval". In the end, the task of the Secretary of State, or the Tribunal, in any given case is simply to assess the obstacles to integration relied on, whether characterised as hardship or difficulty or anything else, and to decide whether they regard them as "very significant".

106. Having taken into account those factors and undertaking a “broad evaluative assessment” I am satisfied that the appellant has demonstrated that the relevant factors relied upon are “very significant” and are such as to meet that high threshold. Thus I am satisfied that he would face “very significant obstacles” to his integration to Ghana and therefore would meet the requirements of paragraph 276 ADE(1) (vi).

107. I therefore remake the appeal by allowing the appeal on human rights grounds for the reasons set out above.

Decision:

The decision of the First-tier Tribunal did involve the making of an error on a point of law and the decision is set aside; the appeal is remade as follows:

The appeal is allowed (Article 3 and Article 8).

Direction Regarding Anonymity – Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008

Unless and until a Tribunal or court directs otherwise, the Appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him. This direction applies both to the Appellant and to the Respondent. Failure to comply with this direction could lead to contempt of court proceedings.

Signed

Date: 1/11/2021

Upper Tribunal Judge Reeds

NOTIFICATION OF APPEAL RIGHTS

1. A person seeking permission to appeal against this decision must make a written application to the Upper Tribunal. Any such application must be received by the Upper Tribunal within the appropriate period after this decision was sent to the person making the application. The appropriate period varies, as follows, according to the location of the individual and the way in which the Upper Tribunal's decision was sent.

2. Where the person who appealed to the First-tier Tribunal is in the United Kingdom at the time that the application for permission to appeal is made, and is not in detention under the Immigration Acts, the appropriate period is 12 working days (10 working days if the notice of decision is sent electronically).

3. Where the person making the application is in detention under the Immigration Acts, the appropriate period is 7 working days (5 working days if the notice of decision is sent electronically).

4. Where the person who appealed to the First-tier Tribunal is outside the United Kingdom at the time that the application for permission to appeal is made, the appropriate period is 38 days (10 working days if the notice of decision is sent electronically).

5. A "working day" means any day except a Saturday or a Sunday, Christmas Day, Good Friday, or a bank holiday.

6. The date when the decision is "sent' is that appearing on the covering letter or covering email.