Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: AA/10453/2015

THE IMMIGRATION ACTS

Heard at Manchester
On 25 January 2018

Decision & Reasons Promulgated
On 23 April 2018

Before

UPPER TRIBUNAL JUDGE LANE

Between

J H
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Ms Patel, instructed by Broudie Jackson & Canter, Solicitors
For the Respondent: Mr Bates, a Senior Home Office Presenting Officer

DECISION AND REASONS

1. The appellant, J H, is a female citizen of Zimbabwe. By a decision which is dated 15 July 2017, I set aside the First-tier Tribunal's determination of the appellant's appeal against the Secretary of State's refusal of her protection claim. My reasons for reaching that decision was as follows:

> "1. The appellant, J H, was born in 1980 and is a female citizen of Zimbabwe. By a decision dated 14 July 2015, the respondent refused the appellant's protection claim. The appellant appealed to the First-tier Tribunal (Designated

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Judge McClure) which, in a decision promulgated on 8 March 2017, dismissed the appeal. The appellant now appeals, with permission, to the Upper Tribunal.

2. The appellant has a child (H) who was born in March 2012. The appellant is HIV positive and is receiving treatment for her condition. Despite claiming that she was at risk from the Zimbabwean authorities, the judge found [71] that the authorities had no interest in the appellant at the time that she left Zimbabwe or that they would have any interest in her now were she returned to that country. In consequence of that finding, the judge dismissed the asylum/humanitarian protection/Articles 2 and 3 ECHR appeals. Granting permission to appeal, Judge McWilliam found that the judge had not arguably erred in his treatment of the asylum/humanitarian protection appeals, the judge not having accepted the appellant's evidence "having made findings that are grounded in the evidence and adequately reasoned." The hearing before the Upper Tribunal on 13 July 2017, therefore, proceeded on the basis of Article 3/8 ECHR and in relation to the appellant's medical condition as provided for in Judge McWilliam's order.

3. I find that the First-tier Tribunal should be set aside. I have reached that finding for the following reasons. First, I note that although the hearing before the First-tier Tribunal took place on 4 November 2016, the decision was not promulgated until 8 March 2017. The delay in promulgation was one of the grounds of appeal to the Upper Tribunal rejected by Judge McWilliam who found that, notwithstanding the delay, that Designated Judge McClure had understood the evidence and issues and had delivered a carefully drafted decision. I agree. However, I do find that the delay has led the judge to fall into error. At [20], the judge refers to the case of Paposhvili v Belgium [2016] ECHR 1113. He quotes from this case at [183] and summarises what he considers to be the principles of law enunciated [21]. He notes that a judicial decision maker is required "among other things [2] to carry out a careful assessment of the facilities of care that would be available in the receiving state." He also considers [22] that "current case law in the United Kingdom" now has to be read in the light of guidance given in Paposhvili. There is nothing particularly controversial regarding what the judge says about Paposhvili. However, the decision in Paposhvili was promulgated on 13 December 2016. The case is also referred to at length by Ms Patel in her grounds of appeal. The problem is that there exists a disconnect between the references made to the authority by the judge and counsel; the judge has applied what he considers to be the principles of the case without giving Ms Patel an opportunity to make submissions in respect of it. Ms Patel submits that the appellant's case under Article 3 ECHR has not been properly considered in the light of Paposhvili. I make no finding in respect of that submission but I do find that this is an instance, given the change in jurisprudence, when the Tribunal could and should have either reconvened the hearing or sought written submissions from the representatives.

4. Secondly, I agree with Judge McWilliam, who granted permission, that the Tribunal's findings at [72 – 73] are not entirely clear. The judge notes that the appellant is receiving "a cocktail of drugs" and that a Dr Chaponda, a consultant in HIV and infectious diseases at the Royal Liverpool and Broadgreen University Hospital in a report dated 27 October 2016 considered that the appellant would "die within a year" if she returned to Zimbabwe and was unable to access her "very complex regimen of antiretroviral treatment." Judge McClure wrote that,

"however at the time that the appellant came to the United Kingdom her viral load was undetectable with a CD4 count of 782. Whilst it has been accepted that this has increased it is to be noted that drug treatment is available in Zimbabwe." I take this slightly cryptic remark to be a suggestion that the appellant had accessed antiretroviral treatment in Zimbabwe (possibly from a Dr Brown who the judge notes had been "willing to obtain supplies of such medication") before she travelled to the United Kingdom. The judge did not, however, make an unequivocal and firm finding that the appellant had actually accessed an appropriate regimen of drugs whilst in Zimbabwe. The judge went on at [73] to "take account of the fact that the report from the hospital indicates that the current course of treatment would not be available in Zimbabwe." However, the judge considered that it was "unclear on what basis the hospital is making that assertion. It was also unclear whether or not it was considered that there may be private means to obtain the medication through individuals like Dr Brown." The judge concluded [74] that, "given all the evidence I find that there may be drugs available, albeit at a price, within Zimbabwe."

5. The problem with the judge's analysis is that the basis for finding that the appellant would "die within a year" had been clearly set out by Dr Chaponda in his letter. The doctor wrote, supporting his prognosis, that, "I know this from my experience in working in Sub-Saharan Africa and the links that I have there." He went on to indicate that he had carried out doctoral work in Sub-Saharan Africa, had worked establishing an HIV clinic from 2006 – 2009 and that he had extensive experience with HIV treatments in Sub-Saharan Africa as well as in the United Kingdom. It was unclear why Judge McClure seems to have been unaware of this basis of Dr Chaponda's prognosis given that it had been clearly stated in the letter. Moreover, the judge has not made any firm finding that the appellant would be able to obtain from Dr Brown (or other individuals) the complex regimen of treatment which she requires. It is also not clear whether Dr Chaponda was aware that the appellant had possibly accessed treatment whilst in Zimbabwe and whether or not he had taken that possibility into account when giving his depressing prognosis.

6. Finally, as regards the application of paragraph 276ADE of HC 395 (as amended), t the judge found that there were no very significant obstacles preventing the appellant's reintegration into Zimbabwe. In reaching that conclusion, the judge does not appear to have taken into account the best interests of the appellant's child H or to have considered whether problems accessing the necessary drug regime would constitute a significant obstacle to the appellant's reintegration. I do not say that such a consideration should have led the judge to a different decision but I do consider these were important factors which should have been addressed in the analysis.

7. In the light of what I have said above, I set aside the decision. Judge McClure's findings regarding asylum are preserved. The only remaining issue before the Upper Tribunal to determine concerns Articles 3/8 ECHR in respect of the appellant's HIV condition. I consider it would be helpful if further evidence was obtained from Dr Chaponda. I therefore make the following directions.

Notice of Decision

8. The decision of the First-tier Tribunal which was promulgated on 8 March 2017 is set aside. The judge's findings as regards asylum are preserved. The only

issue in respect of which the Upper Tribunal shall remake the decision concerns Articles 2/3/8 ECHR and arise from the appellant's medical condition (HIV positive).

DIRECTIONS

(i) The parties shall file at the Upper Tribunal and serve on each other any evidence upon which they seek to rely at the resumed hearing at least 10 days prior to the date of that hearing.

(ii) Permission to the respondent to send questions in writing to Dr Mas Chaponda within 21 days of today. A copy of any such written questions should be filed at the Tribunal and sent to the appellant's solicitors. Dr Chaponda shall reply within 21 days after receipt of such questions. His reply should be sent to the representatives of both parties.

(iii) Within 7 days after receiving Dr Chaponda's written replies, the respondent shall notify the Tribunal and the appellant's solicitor if the attendance of Dr Chaponda at the resumed hearing is required.

(iv) The resumed hearing should be listed before Upper Tribunal Judge Clive Lane on a date at Manchester not before 2 October 2017 (2 hours allowed)

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 or any member of their family. This direction applies both to the appellant and to the respondent. Failure to comply with this direction could lead to contempt of court proceedings."

2. At the resumed hearing at Manchester on 25 January 2018, Dr Chaponda (see above), a consultant at the Royal Liverpool Hospital, attended and gave oral evidence. Dr Chaponda explained that the appellant's current CD4 count had recently fallen and that the viral load in her blood system had become detectable. Without appropriate treatment, her CD4 count will be likely to fall below 200 and that would be likely to occur within twelve months of any adverse change to her current treatment regime. At present, the appellant is on what is known as 3rd line treatment. As the virus mutates it becomes necessary to find new methods of treatment and new combinations of drug therapy. Dr Chaponda said the treatment which the appellant would be able to access (even if she were able to afford to do so) in Zimbabwe was at best 2nd line treatment but more likely 1st line treatment to which her virus has been resistant now for several years. He commented that to treat the appellant with 1st line treatment, was "as good as treating her with nothing". Dr Chaponda said that the appellant would be likely to die within twelve months of return to Zimbabwe whilst should she remain in the United Kingdom, she would be likely to live into her 70s or her 80s.

3. Both representatives made submissions and I reserved my decision.

4. At the time of the error of law decision of this appeal, the law was in a state of some flux. As I noted [3] the First-tier Tribunal had fallen into error for failing to deal

adequately with the case of *Paposhvili v Belgium* [2016] ECHR 1113. Since the date of the promulgation of the error of law decision, the Upper Tribunal has given its view on the relevance of *Paposhvili* in *EA & Ors* (Article 3 medical cases – *Paposhvili* not applicable) [2017] UKUT 445 (IAC). More recently, we have the benefit of the Court of Appeal's judgment in *AM (Zimbabwe)* [2018] EWCA Civ 64. I have had regard to the judgment of the Court of Appeal in *AM* in particular in reaching my determination of this appeal.

5. Whilst the prospect facing this present appellant is uncertain but likely to be distressing, the legal issue in her case is relatively straightforward. I accept Dr Chiponda's evidence that the only treatment which this appellant can access in Zimbabwe is 1st or 2nd level HIV treatment which, as he stated bluntly, is "as good as nothing". In short, the virus from which the appellant suffers will not be adequately or indeed treated at all by such drug therapies as are available in Zimbabwe. There is no evidence to show that the level of drug therapy which this appellant requires is available there, even at a cost. However, given that the appellant receives a drug therapy does not require surgery or more intensive or invasive treatments, the possibility must be considered that she will be able to take with her to Zimbabwe some of the drugs which she will use were she to remain in the United Kingdom. Those drugs, self-administered in Zimbabwe, would have the effect of delaying the onset of the physical decline which the cessation of her treatment would produce. The suggestion that the appellant can take a few months of treatment with her was not raised before the Upper Tribunal and there was certainly no suggestion that she could be treated at a distance by the NHS. I merely refer to the possibility here with a view to underlining the fact that the exact prognosis for this appellant and the speed of her physical decline must, inevitably, remain matters of speculation.

6. What is more clear from the evidence of Dr Chiponda is that the appellant will enter a physical decline and is likely to face an early death. In his submissions, Mr Bates, for the Secretary of State, concentrated upon palliative care. He accepted that there was no treatment available for the appellant in Zimbabwe to actively combat her illness but that it was likely that palliative care including painkillers would be able to manage her pain appropriately. Dr Chiponda was cross-examined about the availability of palliative care in Zimbabwe. Though he had no direct experience of Zimbabwe itself, he had worked in Malawi and was of the opinion that palliative care in sub-Saharan Africa was similar in most countries. Dr Chiponda said that pain relief would be available. It is tempting on the facts of the present case to conclude that to compare the level of treatment which the appellant currently receives in the United Kingdom with the limited palliative care she might receive prior to her death in Zimbabwe is not to compare like with like. Ms Patel, for the appellant, submitted that the mere fact that Mr Bates concentrated upon palliative care was an indication that the Secretary of State accepted that there would, in effect, be no treatment at all available for the appellant in Zimbabwe. However, that argument may be misleading. *N v United Kingdom* [2008] EHRR 39 remains the authority binding upon this Tribunal. The House of Lords accepted in *N* that the appellant would return home and would die. In *N* at [69], Lady Hale formulated the appropriate test as follows:

> "In my view, therefore, the test, in this sort of case, is whether the applicant's illness has reached such a critical stage (ie he is dying) that it would be inhuman treatment to deprive him of the care which he is currently receiving and send him home to an early death unless there is care available there to enable him to meet that fate with dignity. This is to the same effect as the text prepared by my noble and learned friend, Lord Hope of Craighead. It sums up the facts in D. It is not met on the facts of this case."

Two observations arise from Lady Hale's test. First, the present appellant is not at present dying thanks to the excellent treatment which she is receiving. Secondly, there will have appeared to be sufficient palliative care available in Zimbabwe to enable the appellant to "meet her fate with dignity". That palliative care in the receiving country for a person who is dying is an important consideration in a case such as the present is made plain in Lady Hale's judgment. It was not, therefore, inappropriate for Mr Bates to make submissions regarding the availability of palliative care.

7. The Court of Appeal has been careful in *AM* to note that the judgment of the European Court in *Paposhvili* seeks to make only a very modest alteration to the previous jurisprudence. The Court of Appeal at [39] stated:

> "There are a number of powerful indicators, including in the Grand Chamber's judgment itself, which support this interpretation of para. [183] and the inference that the Grand Chamber only intended to make a very modest extension of the protection under Article 3 in medical cases:
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> i) Article 3 is an unqualified right with a high threshold for its application (see N v United Kingdom, para. [43], and also Paposhvili, para. [174]);
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> ii) the Grand Chamber cited with approval at paras. [175]-[181] the ECtHR's previous case-law set out there, including in particular D v United Kingdom and N v United Kingdom, and in doing so it specifically noted at para. [178] that N v United Kingdom was a case in which there had been no violation of Article 3 where removal of the applicant would result in a significant reduction in her life expectancy;
>
> iii) as appears from the Grand Chamber judgments in N v United Kingdom, at para. [43], and in Paposhvili, at paras. [178], [181] and [183], the paradigm case for finding a violation of Article 3 in a medical case is D v United Kingdom, and the Grand Chamber in Paposhvili was only concerned to provide guidance regarding the "other very exceptional cases" referred to in N v United Kingdom at para. [43], i.e. those "where the humanitarian considerations are equally compelling" to those in D v United Kingdom (ibid.; and Paposhvili, para. [178]): see Paposhvili, paras. [181]-[183]. The Grand Chamber in Paposhvili itself recited at para. [177] the circumstances in D v United Kingdom which made it a compelling case and characterised it as a case of "very exceptional circumstances" - it should be noted that this characterisation was not used in the judgment in D v United Kingdom itself, but was stated to be the relevant characterisation of that case by the Grand Chamber in its judgment in N v United Kingdom and is deliberately repeated by the Grand Chamber here in its judgment in Paposhvili;

iv) the Grand Chamber in Paposhvili seeks only to "clarify" the approach set out in N v United Kingdom (see para. [182]), not to effect any major change to what had been authoritatively laid down in that case; and

v) the Grand Chamber at para. [183] in Paposhvili, as well as using the rubric "other very exceptional cases", which itself indicates how rarely the test in Article 3 will be found to be satisfied in medical cases, emphasised in the final sentence that it was still intending to indicate that there was "a high threshold for the application of Article 3" in medical cases. This echoes the point made by the Grand Chamber in para. [43] of N v United Kingdom, set out above, about the high threshold for application of Article 3."

8. At [41], the Court of Appeal stated:

"In that regard, it is also significant that even on the extreme and exceptional facts of the Paposhvili case, where the applicant faced a likelihood of death within 6 months if removed to Georgia, the Grand Chamber did not feel able to say that it was clear that a violation of Article 3 would have occurred for that reason had he been removed. Instead, all that the Grand Chamber held was that the applicant had raised a sufficiently credible Article 3 case that it gave rise to a procedural obligation for the relevant Belgian authorities to examine that case with care and with reference to all the available evidence. The violation of Article 3 which the Grand Chamber held would have occurred if the applicant had been removed to Georgia was a violation of that procedural obligation."

9. The appellant in the present appeal has a minor child with her. The child will return to Zimbabwe with the appellant. Ms Patel submitted that the child's best interests would not be addressed by her returning with her mother to Zimbabwe and there to watch her mother die in possibly some discomfort and pain. Put like that, few would disagree with that argument. However, I am drawn back to the fact that the prognosis of the appellant's physical decline remains a matter of speculation. The appellant's death as consequence of her HIV condition is very likely to occur but when and in what circumstances exactly is not at all clear. I accept Mr Bates's submission that the appellant's decline on return to Zimbabwe is unlikely to be so immediate that she would be unable to care for her child or make arrangements for her future care. I understand that the child has family living in the United Kingdom and, as Mr Bates submitted, it may be necessary in the future for her to return here to be cared for by that family. I also agree with Mr Bates that, as he submitted, that is not a circumstance of today but one of the future. Mother and child will be removed together and, on the most basic analysis, it is in the child's best interest to be with her mother.

10. Sadly, the circumstances of this appellant, although very distressing, are by no means unusual. Applying the ratio of *N* and having in mind also the Court of Appeal's cautious approach to *Paposhvili*, I am not satisfied that the appellant satisfies the test established by the House of Lords in *N* such that she would be entitled to protection in the United Kingdom on Article 3 ECHR grounds. She does not share the extreme circumstances of *D v United Kingdom* and *Paposhvili* does not assist her. In the circumstances, her appeal is dismissed.

Notice of Decision

This appeal is dismissed.

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Signed Date 10 APRIL 2018

Upper Tribunal Judge Lane

No fee is paid or payable and therefore there can be no fee award.

Signed Date 10 APRIL 2018

Upper Tribunal Judge Lane