Neutral Citation Number: [2021] EWCA Civ 421

Case No: C5/2020/1391

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM Upper Tribunal (Asylum and Immigration Chamber)
Upper Tribunal Judge Bruce
HU/16349/2018

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/03/2021

Before :

LORD JUSTICE DINGEMANS
LORD JUSTICE LEWIS
and
LADY JUSTICE ELISABETH LAING

- - - - - - - - - - - - - - - - - - -

Between :

Secretary of State for the Home Department	**Appellant**
- and -	
Deon Starkey	**Respondent**

- -
- -

Mr Zane Malik QC (instructed by **Government Legal Department**) for the **Appellant**
Ms Irena Sabic and Ms Miranda Butler (instructed by **Duncan Lewis Solicitors**) for the **Respondent**

Hearing dates : 11 March 2021

- -

Approved Judgment

Lady Justice Elisabeth Laing DBE :

1. The Secretary of State appeals, with the permission of Newey LJ, from a decision of the Upper Tribunal (Asylum and Immigration Chamber) ('the UT'). The UT had allowed the appeal of Deon Starkey ('the R') from a decision of the First-tier Tribunal ((Asylum and Immigration Chamber) ('the FTT')). The UT held that the FTT had made material errors of law, and re-made the decision. The FTT had dismissed the R's appeal from a decision of the Secretary of State on 25 July 2018 to refuse the R's human rights claim and to deport him from the United Kingdom.

2. It is common ground that the R suffers from paranoid schizophrenia which is controlled by a drug of last resort, Clozapine. Other drugs had been tried over the years, but had not controlled his symptoms. For reasons which I will explain, the first issue on this appeal is whether the FTT erred in law in its approach to the evidence about the availability of treatment for the R's illness in South Africa.

3. On this appeal, the Secretary of State was represented by Mr Malik. Ms Sabic and Ms Butler represented the R. We are grateful to all counsel for their written and oral submissions.

4. The FTT did not make a direction for anonymity in this case, but the UT did. It explained why in paragraph 86 of its determination. Before the hearing of the appeal, this Court notified the parties that it would wish to hear oral submissions from them on the question whether that order should continue. I will return to this issue at the end of my judgment.

The grounds of appeal

5. There are two grounds of appeal.

    i. The FTT made no material error of law in dismissing the R's appeal. The UT erred, therefore, in setting aside the decision of the FTT and in substituting its own decision.

    ii. In any event, the UT itself erred in law in its approach to the application of section 117C(6) of the Nationality Immigration and Asylum Act 2002 ('the 2002 Act'). It failed to recognise that the threshold created by that exception is very high, and reached a decision which was not justified on the evidence.

The legal framework

6. The legal context is Part 5A of the 2002 Act. Part 5A is headed 'Article 8 of the ECHR; public interest considerations'. It codifies in primary legislation the approach which Parliament has decided should be taken by tribunals and courts to cases in which a person resists removal by relying on the rights protected by article 8 of the European Convention on Human Rights. Section 117B lists public interest considerations which apply to all cases. Section 117C lists considerations which apply to 'foreign criminals' (as defined in section 117D(2)). Such cases all involve a balance between the public interest and the article 8 rights of foreign criminals.

7. Section 117C(1) provides that the deportation of foreign criminals is in the public interest, and section 117C(2), that the more serious the offence committed by the foreign criminal, the greater is the public interest in his deportation.

8. Sections 117C(4) and (5) create two exceptions to the general rule created by section 117C(1). The exceptions apply to a foreign criminal ('C') who has not been sentenced to a period of four years' imprisonment or more. The first exception ('Exception 1') applies when C has been lawfully resident in the United Kingdom for most of his life, he is socially and culturally integrated in the United Kingdom, and there would be 'very significant obstacles' to his integration into the country to which he is to be deported. The second exception ('Exception 2') applies when C has a genuine and subsisting relationship with a 'qualifying child' or a 'qualifying partner' (as defined in section 117D(1)).

9. Section 117C(6) applies to a foreign criminal who has been sentenced to a period of four years' imprisonment or more. In such a case, the public interest requires his deportation unless there are 'very compelling circumstances, over and above those described in Exceptions 1 and 2'.

The evidence of the experts

10. The UT's criticisms of the approach of the FTT turn on the FTT's approach to the reports of two experts, Dr Nimmagadda and Professor Ashforth. The UT also relied in its re-made decision on a supplementary report by Professor Ashforth and on a report by Dr Naidoo.

Dr Nimmagadda's report

11. Dr Nimmagadda's report is not dated. It was based on his interview of the R on 4 June 2018. Dr Nimmagadda was instructed to prepare a psychiatric report on the R and to address 11 issues which he listed in paragraphs 17.4-17.16 of his report (report, paragraph 5.1). The report contains a full summary of the R's family background and history. Dr Nimmagadda records that the R reported that his academic performance at school had been good (paragraph 6.3). The R had been working from the age of 15. He had worked in warehouses for many years, and as a systems engineer for two years. He had left that job because of a 'nervous breakdown' in his early thirties. His last job was working as a Ministry of Defence guard for nearly ten years. He reported that he last worked when he was 37 (paragraph 6.4).

12. Dr Nimmagadda summarised the R's medical and psychiatric histories. Section 13 is a full summary of the R's medical records. Dr Nimmagadda noted in paragraphs 13.12 and 13.13 references to the R's work in prison. Paragraph 14.4 of the report refers to his working in a multi-media workshop in prison. In section 15 of the report, Dr Nimmagadda summarised his interview with the R. The R told Dr Nimmagadda that he had done various courses in prison (bricklaying, decorating, OCR business ventures, business finance and computerised book-keeping and accounts (levels 1 and 2). He had also done computer modules for the European driving licence.

13. In paragraph 15.8 Dr Nimmagadda recorded that the R did not feel he needed any particular treatment interventions. He felt he was benefitting from his current medication, but did not want to take it forever and hoped that it could be reduced and stopped at some point.

14. In paragraph 16.4 Dr Nimmagadda noted that the R's insight into his problems was good. Dr Nimmagadda described the improvement in the R's symptoms once he was prescribed Clozapine in 2013. This drug is used for treatment-resistant paranoid schizophrenia (paragraph 17.2). The R had no active or negative symptoms of schizophrenia, though it was likely he had some residual symptoms. He appeared to be 'reasonably stabilised' on Clozapine (paragraph 17.4).

15. Dr Nimmagadda was asked about the prognosis if the R were removed to South Africa 'where arguably he would not get the treatment therapy he requires'. His response was that the likely prognosis was poor, 'if he were not to receive the treatment therapy he requires'. He needed to be 'maintained on Clozapine'. He added that 'this treatment also *necessitates* regular blood monitoring to prevent any *serious* side effect of agranulocytosis (decrease in white cell count in the blood) which is *one of the serious side effects* that occurs in patients who are treated with Clozapine…' (my emphasis) (paragraph 17.7). He also needed to be maintained on anti-depressant medication. It was 'likely that if he were not to have the *necessary* treatment his mental health is likely to deteriorate and he might present with significant risk behaviours, including self-harming behaviours' (emphasis supplied) (paragraph 17.7).

16. A protective factor was the R's good insight into his illness and his need to take medication. He had not shown any 'risk behaviours in prison during the course of his imprisonment'. Support from his family was 'very beneficial to maintain his emotional wellbeing' (paragraph 17.8). He did not express any suicidal ideas and had not harmed himself for more than seven years in prison (paragraph 17.9).

17. The final question Dr Nimmagadda was asked was whether he considered any further issues were relevant. In paragraph 17.14 he said that in his opinion, it was 'unlikely that [the R] will receive *the immediate treatment and monitoring he requires* in his country of origin' (my emphasis). 'Therefore this needs to be clarified before any arrangements for deportation are considered'. The R 'needs to continue to be on clozapine medication, which is a treatment of choice for treatment resistant psychotic illness. He has responded to this treatment…'. His conclusions (paragraph 17.15) were that the R was extremely frustrated and anxious because of his detention and he was emotionally distressed on occasions, but had complied with his medication and engaged with sessions given by a mental health nurse.

18. Dr Nimmagadda's further conclusion, in paragraph 17.16, was that it was necessary to clarify whether the R would receive 'the immediate treatment and monitoring he requires in his country of origin'. The R needed to continue to be on Clozapine. 'He has responded well to this treatment after various anti-psychotic medications had failed to resolve his symptoms of psychosis'.

Professor Ashforth's report

19. Professor Ashforth's first report is dated 23 May 2018. He appears from his curriculum vitae to have done ethnographic research in Soweto and in Kwa/Zulu Natal. He also appears to have an academic interest in witchcraft: see paragraphs 1.2 and 1.3 of his qualifications. The focus of his current teaching is 'global health in African perspectives'. He has no medical qualifications.

20. The first question he was asked was whether mental health services in South Africa were available and adequate in the private and public sectors. His reply was that 'On paper South Africa has an exemplary mental health system'. He quoted from the report by a judge after an arbitration involving the families of 144 dead mental patients and 1400 survivors of a 'torturous' programme of 'deinstitutionalization from a long-term residential service provider' called 'Life Esidimeni', which showed that the treatment of mental patients could be 'torturous and murderous'. This 'tragedy', in his view was 'indicative of the deep malaise of South African public mental health services'. Rich people in South Africa who could pay substantial fees could get excellent treatment. 'For the rest, public facilities have declined to below the

standards once considered inadequate for Blacks'. Two causes were the HIV crisis and corruption and incompetence by officials 'deeply compromised by state capture'; that is, 'the wholesale expropriation of public resources for private purposes'.

21. Hospital-based treatment had been reduced, but the community infrastructure necessary to support that had not been developed. The share of budgets devoted to mental health had declined. An 'already inadequate system has become worse'. There were not enough specialist staff, facilities were overcrowded, treatment protocols were routinely ignored and it was common for supplies of drugs to run out.

22. Professor Ashforth was asked whether mental health treatment was accessible in both the public and private sectors. His view was that, if deported, the R would most likely to be dependent on the public health system for continued treatment. Clozapine was 'available in South Africa although supplies in the public health system are not always reliable'. He added that administration of the drug is 'complex and requires regular monitoring and laboratory tests if possibly fatal side effects are to be minimised'. Administration in the public health system was 'far from satisfactory'. In support of that observation, Professor Ashforth quoted a study of the administration of Clozapine in a 'major mental hospital' in Port Elizabeth in 2013. Footnote 10 shows that the research was a dissertation for the degree of M Pharm by M. Moolman at North-West University. Professor Ashforth does not say what the sample size for the report was; this is not obvious to the lay reader from the material he cites. Nor does he say what period was covered by the research. The report showed that Hospital's metabolic and haematological monitoring of out-patients did not comply with international protocols and guidelines in the vast majority of cases. The report found that the monitoring was inadequate.

23. Professor Ashforth commented that the hospital was a specialist hospital and thus among 'by far the most experienced and knowledgeable institutions dispensing psychiatric medicines in South Africa'. The study suggested that treatment with Clozapine 'consistent with international protocols for schizophrenia is unlikely to be successful in the public sector in South Africa.'

24. He then said that Clozapine and psychiatric treatment would be available in the private sector. The cost of a month's supply of Clozapine and of psychiatric consultations were such that unless the R could get a well-paying job, with health insurance, he would be unlikely to be able to afford the costs of private treatment on arrival. South Africa had a 'substantial social support system'. The R might be eligible for a Disability Grant. The monthly income he would receive from this would cover the cost of Clozapine and one meal in 'a modest suburban restaurant'. Without family support, the R would be 'navigating the extremely complex maze of public health clinics in order to maintain his treatment regimen'. Most people get access to treatment for mental illness in public clinics after being referred by the police.

25. Even if he were not suffering from mental illness, if he did not have 'substantial resources', he would be in serious difficulties. He would have to live in an informal settlement. He would be considered a foreigner and would be 'extremely vulnerable'. His schizophrenia would make him more vulnerable. Many people in Africa interpret auditory hallucinations as 'real communications with invisible beings'. He would be at risk of attack as 'an embodiment of evil spiritual powers intent on causing harm to the community'.

Professor Ashforth's supplementary report

26. Professor Ashforth's supplementary report was produced in response to questions about the impact of the R's racial identity which were asked by the UT in the error of law hearing. He explained that the R was of mixed race. He would be identified in South Africa as 'Coloured'. Such people have always been marginalised in South Africa. Many felt that their circumstances had become much worse since the end of Apartheid. The areas in which they live are subject to control by organised gangs. They are 'extremely dangerous'. The murder rate is very high. The R would be very exposed, and would not be able to rely on protection from the state. South Africa has the 'largest private security industry in the world, with more than 9,000 registered companies employing in excess of 2 million employees'.

Dr Naidoo's report

27. Dr Naidoo had treated the R since March 2019. His report was dated 31 October 2019, so was written when he had been treating the R for just over six months. The R was released from prison on 1 March 2019. The R was deemed stable on his release. His prescription meant that his blood had to be monitored monthly. The R had 'maintained employment' in prison and had complied with his medication.

28. Dr Naidoo saw the R twice: on 8 March and 24 June 2019. He was seen weekly by his care co-ordinator, Mr Harrison, after 25 June. The R appeared settled at the first review. He reported an improvement in his mental state since he had been taking Clozapine. In the June assessment he reported hearing voices in his head, which he described as 'familiar voices'. They would command him to do things but he could generally resist. He had no other psychotic symptoms. His mood was stable. He had no suicidal thoughts. He did feel anxious and had panic attacks. In his contacts with Mr Harrison, 'the overarching theme which contributed to his anxiety was his immigration appeal'. Overall his mental health was stable but anxiety and panic attacks were a recurrent issue. He was to be reviewed in December 2019 and would be started on further medication if his anxiety continued.

29. Dr Naidoo's opinion was that the R had 'some residual symptoms' of paranoid schizophrenia, in the form of auditory hallucinations. The R's needs were complex as he was on Clozapine and needed regular blood tests to monitor his white-cell count. A side effect of Clozapine is that it can reduce white blood cells, and without regular blood monitoring, a patient 'may be prone to life-threatening infections'. There were no emerging risk issues. If the R were deported, he would be in a very vulnerable position. He would have access to Clozapine but there would be 'an absence of the close monitoring and support that he currently receives from his care co-ordinator, as these resources are unavailable in the State sector in South Africa'.

The determinations

30. One of the parties contends that the FTT erred in law, and the other, that the UT did so. I will therefore summarise both determinations, so far as they are relevant to the grounds of appeal, and to the points argued by each side in support of, and in opposition to, those grounds.

The FTT's determination

31. The R is a citizen of South Africa, born in 1972. He claimed to have left South Africa when he was two, although the Home Office could not verify his arrival from its records. The supporting evidence suggested that he had been living in the United Kingdom since 25 October 1977, at the earliest. He was taken into care in 1982. He

stayed in care until he was an adult. He applied for indefinite leave to remain in 1999. It was granted on 12 February 2001.

32. In 2011, he was convicted of two counts of indecent assault on a female under 14, three counts of gross indecency with a child under 16, and one count of rape of a female who was less than 16 years old. He was sentenced to eight years' imprisonment. He was required to register on the Sex Offenders Register for life, and banned from working with children for life.

33. The Parole Board authorised the R's release from a date in early 2016. The R was then detained under immigration powers. A decision was served on the R which wrongly stated that he only had an out-of-country right of appeal. In 2017, he was deported to South Africa, but was not admitted because his escorts had not brought an emergency travel document which had been issued to the R. The R was then admitted to the United Kingdom for the necessary documents to be obtained. In 2018, removal directions were set, but cancelled when the R was admitted to hospital after having some seizures. The R's solicitors made further submissions on his behalf.

34. The FTT set out the R's case in paragraphs 10-31 of its determination. This summary was said to be based on his witness statement. The R said that he had entered the United Kingdom when he was two. He had entered on his own passport, with his grandmother. His mother had arrived a year earlier. He never knew his biological father, whom he has only seen on-line a few years ago. He thought that he had been given indefinite leave to remain in 1977. In 1987 he was convicted of three counts of burglary and theft. He was given a supervision order for two years.

35. His case was that the Secretary of State had failed to keep him properly informed before the decision in 2018. The actions of the Home Office had caused him much distress and affected his mental health. Had he been released with 'a robust risk management plan' which was ready in 2015, his mental health would have improved greatly.

36. The FTT recorded R's description of his family in the United Kingdom in paragraph 20 of its determination. He had a good relationship with three members of his family. His account was that he had suffered physical and emotional abuse from his mother and stepfather. He felt rejected by them. He left home at 14 and spent two years in a children's home. He left school at 16 and found a job. He had had various jobs since then, but not since 2008, after a breakdown. He said that he had serious issues with his mental health over the years. They peaked in about 2009, when he tried to commit suicide. Voices in his head told him to harm himself. He slashed his wrist once, in front of his mother, was taken to hospital but quickly discharged. The voices got worse, and he again tried to take his own life. He jumped off a bridge into the River Thames. He was rescued and was in hospital for nearly two months. He was diagnosed with paranoid schizophrenia.

37. The FTT recorded that the R understood the public interest in his deportation but that he argued that there were very compelling circumstances in his case which outweighed that interest. The Secretary of State accepted that the R was socially and culturally integrated in the United Kingdom but that his integration was undermined by the seriousness of his offences, which showed a disregard for the law. The R did not understand the Secretary of State's assertion that he could integrate in South Africa because he had only spent his first two years there. He had been in the United Kingdom lawfully for 36 years, if his period of imprisonment was left out of account.

38. He had only ever known the British way of life. He had no family he was aware of in South Africa. His entire support system was in the United Kingdom. Without the support and encouragement of his family in the United Kingdom, he could not see how he could cope in South Africa. The Secretary of State claimed he could get work in South Africa, but had not realised the extent of his mental illness, and its effect. He had been unemployed for three years before his imprisonment. His mental health had stabilised and he was not a risk to himself and others. He could think and function properly. Without a robust management plan, the necessary support and medication, his condition would deteriorate fast. He had a history of self-harm and tried to commit suicide.

39. He relied on the strong social stigma associated with severe mental illness. It would be very hard for him to find a job. No-one would want to employ him for fear his condition would relapse. The chances of that were much higher in South Africa than in the United Kingdom because he would have no support from family and friends there. His mother and siblings had not been able to visit him because of the long distance, the money to travel to visit him in prison. His mother had health problems, but they spoke regularly on the telephone.

40. The R deeply regretted his actions.

41. There would not be sufficient care for him in South Africa. The Secretary of State's objective evidence dated from 2005, whereas the report of his expert, Dr Ashforth, was based on sources published in 2017. The severity of his mental illness, if his medication were not managed, and the lack of support in South Africa could make him a target. The Secretary of State had failed to take into account that if removed, the R would be homeless, and a risk to himself and others if his medication were not managed. He would not have the money to pay for medication, even if he could get access to it. His mother and siblings would not be able to support him financially or to protect him from physical harm. They lead their own lives in the United Kingdom and have their own expenses. They have rebuilt their relationship and rely on each other for moral and psychological support but they would not be able to send money to him in South Africa to support him financially and keep him safe.

42. The FTT summarised the Secretary of State's case in paragraphs 3-38. The Secretary of State submitted that the R's deportation was conducive to the public good and in the public interest because of the seriousness of the R's offences. The public interest required deportation unless there were very compelling circumstances, over and above those set out in Exceptions 1 and 2. Evidence of a very strong article 8 claim was needed to outweigh the very strong public interest in deportation.

43. The Secretary of State contended that there would be no obstacles to the R's reintegration in South Africa. The R had no family ties in South Africa, but he was 45 and it was not unreasonable to expect him to live independently there. He had provided no evidence to show that he could not get a job. Anyone who had a family or other relationship with the R would be able to support him financially and emotionally while he established himself in South Africa.

44. The Secretary of State relied on the sentencing remarks of the judge. He accepted that the R was 'psychologically vulnerable' but recorded that it had not been suggested to him at sentence that he should use his powers under the Mental Health Act 1983. He also recorded that the offences had started when the R was fifteen and his victim was five years old. She must have suffered psychologically and her normal adult

relationships would have been undermined by the destruction of the R as a role model. The abuse continued until the R was in his early twenties. He had abused his role in relation to her. His victim had probably been fifteen when he raped her. The offence was 'a one-off offence, it was a short offence, there was limited violence…'

45. The Secretary of State did not accept that there were very compelling circumstances which outweighed the public interest in the R's deportation. The Secretary of State had considered the R's claim that his deportation would breach article 3. The objective evidence did not confirm the report from Dr Ashforth which said that it would be difficult for the R to get adequate treatment in South Africa. The Secretary of State also claimed that the R's mother could support him financially in South Africa from the United Kingdom.

46. The FTT heard evidence from the R. He adopted his witness statement dated 26 October 2018 which the FTT had summarised. As the FTT recorded, it considered a witness statement from the R's mother, but did not give it great weight, as she did not attend the hearing, and gave no explanation for that (paragraph 59).

47. In paragraphs 40-86 of the determination are headed 'Consideration and Reasons'. The FTT described the legal framework. There is no criticism of that exposition. In paragraph 45, the FTT said that it had to consider 'to what extent' the R's 'circumstances' fell within Exception 1 or 2, recognising that that was not determinative of the question posed by section 117C(6), but that it was a 'helpful starting point'. The FTT added, 'I am also aware that those factors that are not encompassed in Exceptions 1 and 2 can be considered holistically under this provision'.

48. The FTT concentrated on Exception 2, as Exception 1 was not relevant (paragraphs 46 and 47). The FTT accepted that the R came to the United Kingdom when he was two, and that he had been lawfully resident in the United Kingdom for most of his life (paragraph 49). The FTT also accepted that the R was socially and culturally integrated in the United Kingdom (paragraph 52). The issue was whether there would be 'very significant obstacles to his integration in South Africa' (paragraph 53). The R no longer had ties to South Africa (paragraph 54). The R had 'no real close ties with his family' in the United Kingdom (paragraph 55).

49. The FTT summarised the somewhat contradictory evidence about the support, emotional and practical, which the R's family might provide him with in the United Kingdom and in South Africa (paragraphs 56-60). By the time of his FTT hearing, the R had been in prison, either serving his sentence, or in immigration detention, for about seven years. No member of his family had visited him in prison (paragraph 58, last two sentences). In the light of that, the finding in paragraph 55, and the fact that none of his family had attended the hearing, the FTT could 'not simply accept the evidence of [the R] and his mother that [his family] would provide him with emotional support…' (that is, in the United Kingdom). Even if the FTT could accept that the R's family would give him some sort of support in the United Kingdom, the FTT found that such support 'including the emotional and financial support can be given to the [R] in South Africa' (paragraph 60).

50. The FTT recorded the R's submission that his mental health conditions would be very significant obstacles to the R's integration in South Africa. The R relied on the report of Dr Nimmagadda. The FTT summarised that report at paragraphs 61-64 of its determination. That summary is very full. It is accurate, so far as it goes, apart from

the fact that, as Ms Sabic pointed out, the FTT seems to have thought R's current medication was Olanzapine, not Clozapine. However, as she also pointed out, the summary does not refer to the need for regular blood monitoring to avoid a serious side effects (see paragraph 17.7 of Dr Nimmagadda's report, referred to in paragraph 15, above).

51. Mr Malik submitted that paragraph 63 was significant because it contained four findings, which were securely based on Dr Nimmagadda's assessment of the R.

    i. The R was not, on his current medication, having any positive symptoms, such as command hallucinations.

    ii. The R was not having any negative symptoms, such as apathy.

    iii. He had some residual symptoms. He heard voices occasionally, but was reasonably stable on his medication.

    iv. He had no active symptoms of depression.

52. The FTT's conclusion was 'It is clear from the evidence that [the R's] current regime of treatment is in the form of medication. There is no satisfactory evidence before me to suggest that [the R] will not receive the immediate treatment that he requires. I accept that disparity in treatment does not assist [the R]'.

53. In paragraphs 67 and 68, the FTT considered the report of Professor Ashforth. The FTT took into account the Secretary of State's comments on the report. I interpose that those 'comments', in the decision letter, were simply that 'Dr Adam Ashworth have also claimed that it will be difficult for you, however the objective evidence does not confirm this'. It does not appear to me that the decision letter identifies or cites objective evidence which is inconsistent with that statement.

54. In paragraph 68, the FTT referred to a submission for the R that if he were deported to South Africa, he would be likely to depend on the public health system for continued treatment, a system which had 'declined substantially'. The FTT recorded a concession that 'Olanzapine' (Clozapine must be meant) was available in South Africa, although supplies in the public system were not always reliable. The FTT recorded a further submission that unless the R could get a well-paying job, with health insurance, 'on arrival it is unlikely he will be able to afford the costs of private treatment'.

55. The FTT took into consideration, in paragraph 69, that the R's paranoid schizophrenia was stable on medication 'and that there is no satisfactory evidence before me to suggest that [the R] will not be able to receive the medication and treatment (if necessary) for his mental health conditions'. The FTT then explained why it found that 'there is no reason why [the R] would not be able to find some form of employment in South Africa'. He was of an age and maturity to be able to 'start a new life there without family support'. The FTT concluded that the R's mental health conditions would not impede his integration in South Africa.

56. The FTT went on to consider, in the light of that analysis, whether there were 'very compelling circumstances over and above' Exception 1. For the reasons it gave in paragraphs 73-86, it held that there were no such circumstances. It noted that the R had not pleaded guilty. It acknowledged that a low risk of re-offending was one facet of the public interest, but in the case of serious crimes, not the most important, though

it could be an important factor in a few cases. His rehabilitation and the low risk posed by the R should not be treated as an important factor in this case. Further, the R 'was assessed as posing a medium risk of causing serious harm to children and while the risk of re-offending was assessed as low, it was not negligible'.

The determination of the UT

The hearing

57. The heading of the determination suggests that there was only one hearing, on 10 February 2020. Internal evidence (in particular paragraphs 63 and 64 of the determination; see paragraph 71, below) suggests that there were two hearings: a hearing at which the UT heard argument about whether the FTT had erred in law, decided that it had, and a further hearing to enable it to re-make the decision. I do not know the date of the first of those hearings. At those hearings, the R was represented by counsel, and the Secretary of State by a Senior Presenting Officer, Mr Tan. It seems from internal evidence that Professor Ashforth was present at at least one of those hearings. The Secretary of State has helpfully confirmed, in response to the draft judgment, that there were indeed two hearings; on 19 July 2019 (the error of law hearing) and on 10 February 2020, when the decision was re-made.

The decision to set aside the determination of the FTT

58. The hearing was on 10 February 2020. The UT summarised the FTT's determination (UT's determination, paragraphs 7-8). It summarised the five grounds of appeal in paragraph 10. The second ground of appeal was that the FTT had failed to take material facts into account, in particular, that the FTT had found that the R would be able to find work and support himself in South Africa, so enabling him to buy the medication/ treatment he needed for his paranoid schizophrenia. The FTT had failed to have regard among other things to the impact of his illness on his ability to orientate himself and so get work within a reasonable time of his arrival. In fact, it was said, the evidence was that the R was 'very unlikely to be able to secure employment and/or access his medication within a reasonable time'.

59. In paragraph 21, the UT said that the 'crux' of the appeal was whether the R was 'actually able to establish some kind of meaningful private – or family – life…in South Africa'. If the effect of removal would be that 'his mental health spirals out of control and that he finds himself a stranger in a strange land, living rough…scavenging for food and presenting an easy prey for criminals, it could be said that his would amount to "very compelling circumstances" of the sort that might tip the balance, no matter how deeply abhorrent his crimes. The analysis of [the R's] personal characteristics, and how he might fare in the South Africa of today, was therefore determinative'.

60. The UT described the R's medical history in paragraph 22. It said that it seemed that medication had kept the R stable, or contributed to his stability. In paragraph 23, it added that 'the evidence about the availability of [the R's] treatment regime in South Africa was of some significance'. If it could be maintained, 'this would support the [FTT's] conclusion that [the R] would be able to surmount obstacles such as obtaining work, housing, friends, and all the other constituent parts of a normal life. If it could not, then this would throw that conclusion into doubt'.

61. The UT recorded the R's concession that the drugs the R needs are available in South Africa (determination, paragraph 24). This concession was rightly made. The expert evidence which dealt with this issue, of Dr Naidoo (which had not been before the

FTT, but was before the UT) and of Professor Ashforth were clear about this. The UT said that Professor Ashworth's report showed that the drugs were available privately, for those with the money to pay for them. They were also available in the public healthcare system, albeit supplies were 'not always reliable', and according to one 2013 study, in one leading hospital, the monitoring and prescription of the drugs did not comply with international protocols. The UT said that Professor Ashforth's conclusion was that unless the R could get a well-paying job with health insurance, it was unlikely that he would be able to afford the costs of private treatment. If he were eligible for a Disability Grant, that would leave him with very little money after buying a month's supply of medication. He would have 'difficulty in navigating the extremely complex maze of public health clinics…'

62. The UT recorded that it was against that background that the R submitted that the FTT was not rationally entitled to conclude, in paragraph 66 of its determination, that 'there is no satisfactory evidence before me to suggest that [the R] will not receive the *immediate* treatment that he requires'. The R accepted that the FTT had 'register[ed] some regard to' Professor Ashforth's report, but asked the UT to note that that reference came only after the conclusion at paragraph 66. It is a small point, but this particular criticism of the FTT is unfair, since paragraph 66 expresses its conclusions about the evidence of Dr Nimmagadda, whereas the FTT considered Professor Ashforth's report after that, in paragraphs 67 and 68 of its determination.

63. In paragraph 28, the UT accepted that the FTT 'did err in fact when it said that there was "no satisfactory evidence" to suggest that treatment would not be "immediately available"', as that was the whole import of Professor Ashforth's 'unchallenged and uncriticised, evidence'. Looking at the determination as a whole, it was possible to say that the FTT had in mind the later conclusion, expressed in paragraph 69, that the R would be able to find work and support himself. If that were so, he might be able to afford the medication he needed, but 'It is, however, difficult to see here that the [FTT] has had regard to the mechanics: if [the R] needs a job to get his medication, it is extremely unlikely that his access to medication would be "immediate"'. No consideration had been given to whether the R's history, mental illness and long absence from South Africa might affect his ability to find work.

64. The UT then quoted a long passage from Professor Ashforth's report, which it described as 'a bleak assessment' which the FTT's determination did not deal with. This is the passage in which Professor Ashforth speculates about what might happen to the R if he returned to South Africa with little or no money, and with no social network, problems which would be made worse by the R's schizophrenia, and by the likely reaction to that because of the views of 'many people in Africa' to auditory hallucinations, and the risk of attack to which those might expose him.

65. The UT said that given the views of Dr Nimmagadda that the R has auditory hallucinations even with his medication, this evidence was 'obviously pertinent to whether [the R] would be able to safely re-establish himself in South Africa. The omission to weight it in the balance was an error of law' (paragraph 30). It was 'fundamental to the overall decision'. It followed that the decision should be set aside (paragraph 30). The UT observed that 'the appeal is likely to turn on [the R's] likely circumstances upon return to South Africa. Either they will drop below the level considered acceptable in humanitarian terms, or they will not' (paragraph 33).

The re-made decision

66. At paragraphs 35, 36, 37 and 53, the UT correctly stated and described the relevant test. The UT referred to it as 'an extremely high threshold', and 'an extremely demanding test'. The UT echoed the statement that ' "Compelling" means circumstances that have a "powerful, irresistible and convincing effect"'. The UT said that 'only the most extreme consequences could justify allowing this appeal'. The UT was careful not to equate the test with the test for establishing a breach of article 3, but 'in a case like this the threshold must be approaching that highest of benchmarks'.

67. The UT then considered a range of factors, and whether they should be given any weight in the proportionality balance. The UT attached 'some weight' to the fact that the R had lived in the United Kingdom for all of his conscious life (paragraph 43). The UT gave no extra weight to the probability that, had he applied for it at the right time, the R would have been entitled to British nationality (paragraphs 44-47). The UT gave some weight to the R's history of 'Childhood Trauma' (paragraphs 49-50 and 52; the sentencing judge had said, '…it is very easy to understand, as you say yourself, how the abused became the abuser'). The UT gave some, but 'necessarily limited' weight to the low risk of re-offending posed by the R, and to the fact that he had committed no crimes for 23 years. The UT also appears to have given weight to the fact that the R's crimes only came to light by his own confession (paragraph 52).

68. The UT then turned to the 'elements of [the R's] case which in my view attract the greatest weight: the obstacles that he will face in returning to South Africa…' (paragraph 53). The UT considered the R's health in paragraphs 54-58, drawing principally on the reports of Dr Nimmagadda and Dr Naidoo.

69. The UT summarised that psychiatric evidence in paragraphs 56-57. In paragraph 58, she referred to more recent evidence which was given to the UT on the day of the resumed hearing, dated 7 February 2020. The UT summarised the R's work history in paragraph 59. The prison service had confirmed that the R had worked throughout his time in prison. He had managed, 'at least until he became too unwell, to hold down several good jobs.' The UT listed those.

70. The UT then referred to two reports from Professor Ashforth. It had summarised those already. It described 'The global conclusion reached by Professor Ashforth…' in paragraph 61. This summary, however, is materially inaccurate, as its focus is the cost of paying for Clozapine privately. It does not refer at all to the availability of Clozapine in the public health system, but instead makes a general criticism of the decline of public health facilities since the end of apartheid. In paragraph 62, the UT referred to the 'added difficulty of the cultural response towards mental illness'. The UT cited this material again (it was quoted at length in paragraph 28).

71. In paragraph 63, the UT referred to evidence elicited from Professor Ashforth at the resumed hearing about the problems which the R would experience because of his 'racial identity' as what is known in South Africa as a 'Coloured' person (that is, as the UT explained, a person of mixed race, or dual heritage). The UT had specifically asked Professor Ashforth to comment on that. That evidence resulted in an addendum report by Professor Ashforth dated 25 October 2019. The UT summarised that evidence in paragraphs 63-66. In short, the R would have to live in a 'Coloured neighbourhood' all of which were controlled by criminal gangs. The R would need, but would not have, protection from a social network or from the police.

72. The UT observed that Mr Tan took no particular issue with Professor Ashforth's analysis of South Africa society, but that he objected 'strongly' to the way in which

Professor Ashforth had interpreted the evidence about the availability of drugs and treatment for the mentally ill. Mr Tan referred to the two primary sources relied on by Professor Ashforth. He argued that according to the WHO Report, 80% of the population has access to free psychotropic medicines, and they were available at 'minimal cost' (as low as 24 cents a day). The 'Stop Stockouts' report, published in 2017 (which deals with the availability of medicine in South Africa) showed that various anti-psychotics were available in over 90% of the facilities which usually stock medicine.

73. The UT said that 'having considered all of the evidence,' it was 'satisfied that Professor Ashforth's research was valid' and that it could be given weight. The WHO report dated back to 2007 and only referred to generic anti-psychotics. It was unclear whether it was inconsistent with 'the very specific evidence of Professor Ashforth about Clozapine, and its current cost of R1087 per month…'. The recent 'Stop Stockouts' report did not refer specifically to Clozapine.

74. Paragraphs 69-85 are headed 'Discussion and Findings'. The weight to be attached to the public interest in deportation was 'very great indeed'. The cumulative weight of the 'UK factors' was 'indeed compelling'. They fell short of displacing the public interest in this case, however. The UT considered that the 'likely consequences' of returning to South Africa were 'far more significant' (paragraph 69).

75. The UT found that the R 'would have little to no chance of integrating' in South Africa 'in the sense of establishing a meaningful private life' (paragraph 70). The UT was satisfied that the final limb of Exception 1 was established (paragraph 71). The UT then considered whether there were very compelling circumstances over and above Exception 1. The UT started this section of its determination by describing the R's illness, which it considered was his 'defining characteristic', and its effect on him. The R had continued to have symptoms for many years, despite treatment, which he still had, 'even after many years on the drug of last resort for his condition, Clozapine' (paragraphs 73-76). The UT would assess the likely events after deportation, by 'imagining, in the light of the known facts, what the best case scenario might be' (paragraph 76).

76. The best-case scenario was that the R arrived with enough medicine to last until his next blood test. The Secretary of State had given no undertaking to that effect. I interpose that that might have been because, as the decision letter suggests, the R had not (at least, at the point when the decision was made) consented to the communication of any medical information to the authorities in South Africa. That is supported by paragraph 17 of the R's witness statement.

77. If the R arrived in a Coloured neighbourhood with enough money for a month's rent and food, the UT found it hard to see how he would manage after his money ran out. He would be easy prey for criminals. Even on his medication, the R continued to hear hostile voices, and experienced intense feelings of paranoia, anxiety and panic. Professor Ashforth had written extensively about witchcraft. The R would be at risk of being attacked. If A's symptoms stayed constant, those conditions would 'significantly impede' his ability to find work and to negotiate the maze of the public health system. He would have a month in which to find a clinic and to have his blood monitored for a further prescription of Clozapine. This would be a huge challenge which the R would be unlikely to be able to surmount. He was so anxious that he was housebound.

78. The debate about whether Clozapine was readily available in South Africa 'receded in significance'. The UT could accept that the R 'in his anxiety-riddled and psychotic state' could find a clinic where the drug was available at no or little cost. There must, however, 'be serious concerns about whether the blood testing and monitoring would be conducted, leaving the drug with reduced efficacy and compromising [the R's] immune system'. Even if he could find a clinic 'complying with international prescription norms', he would know no-one, and with 'serious mental health issues' he would be trying to integrate into one of the most violent societies in the world (paragraph 83). That was the 'very best case scenario' the UT could 'envisage' for the R. The UT found that the cumulative challenges faced by the R 'are such that the very high test' was met. The public interest required the R's deportation but 'not at the expense of the United Kingdom's obligations under the ECHR'. The UT was unable to find that the conditions faced by the R would be anything less than inhuman and degrading'.

79. The UT considered it more likely that the stress of deportation would, as Dr Naidoo and Dr Nimmagadda thought likely, make the R's illness worse. It was more likely than not that the R's deportation would cause his health to 'spiral downward'. Anyone he spoke to would be able to see that he was not 'normal'. It was very difficult to see how he could get a job or find somewhere to live. He would very quickly after arrival run out of money and drugs and find himself on the streets. 'The public interest does not require that'.

Anonymity

80. The UT acknowledged that, as criminal, the R's identity would not normally be protected. The UT was concerned that disclosure of his identity could lead to the identification of his victim. Further, in accordance with Presidential Guidance Note No 1 of 2013 ('the Note'), the medical evidence made it appropriate for there to be an anonymity order in accordance with rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008.

Submissions

Ground 1

81. Mr Malik started his oral submissions with five points, for which he cited the relevant authorities, which supported his overall submission that the UT should, in general, exercise restraint in the exercise of its jurisdiction to find errors of law in a decision of the FTT. The UT should not overturn a decision of the FTT just because it disagrees with the outcome. The UT should not turn infelicities of expression, or small gaps in reasoning into errors of law. It can sometimes be inferred that the FTT has taken material into account, even if it has not mentioned it expressly. The FTT is a specialist tribunal and can be taken to know the law unless its determination shows clearly that it has not stated the law correctly. We do not disagree with any of those propositions. They apply as much to the Court of Appeal, when it is invited to find an error of law in a decision of the UT, as they apply to the UT when it is invited to find an error of law in a decision of the FTT.

82. Mr Malik submitted that paragraph 63 of the FTT's determination contained findings of fact about the medical evidence which the UT should not have overturned. It was open to the FTT to find, as it had, that the R's regime of treatment was medication, and that that would be immediately available to the R through the public health system. It was open to the FTT to say that a 'disparity in treatment' did not help the R. He emphasised the qualifying phrase 'if necessary' in paragraph 69 of the

determination. The phrase 'not always reliable' in Professor Ashforth's report meant exactly that. The FTT was entitled to find that the R would get a job of some kind. He had worked throughout his time in prison.

83. He contended that paragraph 12 of the UT's determination, in particular, showed that its approach was not to ask whether the FTT had erred in law, but rather, that its approach was the articulation of a disagreement with the FTT's conclusions, which conclusion had been open to the FTT on the evidence. That point was supported by the language of the next two paragraphs of the UT's determination. The UT had also erred in paragraph 28 in criticising the FTT's finding in paragraph 66, by focussing on the availability of private healthcare and the 'mechanics'. The FTT was aware of Professor Ashforth's report and referred to it. It did not err in law in not citing material from that report. The UT had also erred in concluding that the R was having auditory hallucinations, as the evidence of Dr Nimmagadda was that his psychotic illness was stable and he was only having occasional 'residual' symptoms.

84. Ms Sabic submitted that the FTT had not explained its conclusion in paragraph 69. It was not enough to state a conclusion without giving reasons for it. The requirement of anxious scrutiny, which applies in this context, reinforced that point. Paragraphs 63 and 69 were significantly inaccurate accounts of the evidence. The FTT had failed to grapple with the evidence of Dr Nimmagadda that the R needed his white-cell count to be monitored. The evidence of Professor Ashforth was either unchallenged, or not challenged in any material way. In this context, the duty of anxious scrutiny required the FTT to explain what it had made of the evidence that the R needed to have his white cell count monitored regularly, that there was some doubt whether that monitoring would be available in the public health system, and why that evidence, which was not challenged, was not an obstacle to the FTT's conclusions that 'there was no satisfactory evidence before me that [the R] will not receive the immediate treatment he requires' and 'there is no satisfactory evidence before me to suggest that [the R] will not be able to receive the medication and treatment (if necessary) for his mental health conditions'. The FTT had expressed two conclusions but had not explained them.

85. Mr Malik made two submissions on ground 2.

    i. The UT had erred in law by disregarding, without proper justification, the evidence that if R re-offended, he posed a medium risk of serious harm to children if he were to re-offend. The UT, moreover, had, in paragraph 57 of its determination, attached some weight to rehabilitation and risk.

    ii. It was clear from the second paragraph of the UT's citation of Professor Ashforth's report in paragraph 28 of its determination that it had adopted Professor Ashforth's characterisation of the effects of R's illness rather than that of Dr Nimmagadda. Paragraph 29 of the determination, further, showed that the UT had misunderstood Dr Nimmagadda's evidence, because it had interpreted that evidence as showing that the R had significant and obvious symptoms of his illness, even on medication. That misunderstanding of the severity of the R's illness when he was medicated undermined that UT's assessment of the impact on the R of returning to South Africa in paragraphs 77-84: see, in particular, its references to 'a range of

symptoms' in paragraphs 81, 82 and 83 ('his anxiety-riddled and psychotic state'). The UT had departed, without explanation, and without justification, from the FTT's accurate summary, in paragraph 63 of its determination, of the R's current condition.

86. Ms Sabic had two responses to Mr Malik's first argument on ground two.

    i. The UT did not err in law in not referring the quality of the risk of re-offending; it was the bare risk which was significant.

    ii. If that was wrong, any error was immaterial, because the UT had, in any event, given little weight to the risk of re-offending.

87. Her response to the second argument was that there had been no meaningful challenge to the evidence of Professor Ashforth or of Dr Nimmagadda or Dr Naidoo. The UT's decision was very detailed and very clear.

Discussion

88. I have summarised the determinations and the submissions in some detail. This section of my judgment can be relatively short.

Ground 1

89. I consider that the FTT's approach was wrong in law in two linked ways.

90. First, it was clear from the report of Dr Nimmagadda that, in order to guard against the serious side effect of a reduction in the R's white blood cell count, R's blood had to be monitored regularly. Professor Ashforth's report suggested, to put it no higher than this, that there was doubt about whether that monitoring was available in the public health system. The FTT did not refer, in paragraph 63, or in paragraph 69, to this requirement for regular monitoring, or to that doubt. That was a material omission from an otherwise full and accurate summary of the relevant evidence.

91. The conclusions expressed in paragraphs 63 and 69 use the same formula, 'There is no satisfactory evidence that…'. The formula is ambiguous. It could be a loose way of saying that there was no evidence, or it could mean that there was evidence, but that the FTT did not consider that it was satisfactory. If the formula has the first meaning it is a materially inaccurate account of the evidence. If it has the second meaning, it begs a question, which is why the FTT considered that the evidence was not satisfactory. In this context of anxious scrutiny, the FTT should have explained why it considered that the evidence was unsatisfactory. I note that, elsewhere in the determination, the FTT did exactly that. In paragraph 59, the FTT was considering what weight it should give to witness statement made by the R's mother, who did not attend the hearing. The FTT found that 'no satisfactory evidence was given by [the R] as to why his mother was not in attendance at the hearing. He simply stated that he was informed by his solicitor last week his mother was not going to attend'. Whatever the FTT meant by this formula, its use in paragraphs 63 and 69 was wrong in law. That is the second flaw in its approach.

92. It follows that the UT did not err in law in setting aside the determination of the FTT.

Ground 2

93. Mr Malik, rightly, did not submit that the UT asked itself the wrong question. It is clear from several passages in its determination that it correctly understood that the test posed by section 117C(6) of the 2002 Act is a very demanding one. The harder a

test is to meet, however, the more important it is to marshal the relevant factors on each side so that they can be given the weight which the tribunal considers appropriate, and balanced against one another.

94. I accept Mr Malik's submission that the UT misunderstood the evidence about the severity of the R's illness when he was receiving the appropriate medication. It appears to have thought that, even with medication, the R would have great difficulty when he arrived in South Africa both in finding a clinic and a job. That approach is inconsistent with the evidence that R's illness was stable with his medication, that he had worked throughout his time in prison (even though he did not have the right medication throughout), and had gained various vocational qualifications there. That misunderstanding is an essential foundation of the UT's reasoning about what would happen to the R on his return. It means that the UT's conclusion that the demanding test in section 117C(6) was met cannot stand.

95. That makes it unnecessary for me to express any view about Mr Malik's first argument on ground two. I am inclined to think that, even if the argument was correct, it would not, on its own, have led me to allow the appeal. The UT gave only 'some, but necessarily limited' weight to the low risk of re-offending. That was one of a group of factors ('the UK factors') the collective weight of which, the UT considered, was 'indeed compelling' but which did not displace the public interest in the R's deportation. The UT said that the 'likely consequences' of the R's return to South Africa were 'far more significant' (see paragraphs 53 and 69).

Conclusion

96. I would allow the appeal of the Secretary of State on ground 2 and remit the appeal to FTT for it to consider it again in the light of any up-to-date evidence which the parties wish to rely on.

Anonymity

97. The UT rightly recognised that the fact that the R had committed a serious crime was an argument against anonymity. It made an anonymity order because it was concerned that if the R were not anonymised, there was a risk that that might lead to the identification of his victim. It also considered that an anonymity order was 'appropriate' because of the medical evidence in the case.

98. As My Lord, Dingemans LJ pointed out in argument, the Court of Appeal (Criminal Division) does not anonymise defendants in appeals relating to sexual offences, as it is clear that the victim of a sexual offence is, independently, entitled to life-time anonymity, pursuant to section 1 of the Sexual Offences (Amendment) Act 1992. I therefore consider that the first reason which the UT gave for anonymising the R was not a good one. I also consider that this was a case in which it was not necessary to anonymise the R. It is impossible to understand the arguments in this appeal without an exposition of the medical evidence. The serious crimes committed by the R, and the open justice principle, outweigh any article 8 considerations in his case. For those reasons, I would not continue the anonymity order made by the UT.

Lewis LJ

99. I agree.

Dingemans LJ

100. I also agree.