IAC-PE-AW/SW-V1

Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Numbers: IA/38588/2014
IA/38589/2014
IA/38590/2014

THE IMMIGRATION ACTS

Heard at Manchester
On 14th January 2016

Decision & Reasons Promulgated
On 16th March 2016

Before

DEPUTY UPPER TRIBUNAL JUDGE BAIRD

Between

O S O (FIRST APPELLANT)
A O O (SECOND APPELLANT)
A M O O (THIRD APPELLANT)
(ANONYMITY DIRECTION MADE)

Appellants

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellants: Ms L Mair - Counsel
For the Respondent: Mr McVeety – Home Office Presenting Officer

DECISION AND REASONS

1. These are appeals by Mr O S O and his wife and older child to whom I shall refer throughout this decision as AM. There is a younger child dependent on his father's appeal. The dates of birth of the Appellants are 4th October 1974, 24th June 1978 and

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22nd October 2007 respectively. The younger child was born in the UK on 22nd January 2012).

2. The First Appellant arrived in the UK on 22nd August 2007 with a student visa valid to 3rd January 2011. This was extended twice expiring on 12th April 2012 at which point the First Appellant was granted leave to remain on a Tier 1 (Post-Study) Visa for the period 25th July 2012 to 25th July 2014. His wife and the elder child had visas in line with him and did not come to the UK with him. They were here from 17th October 2009.

3. Because two children are involved in this appeal I make am anonymity direction.

4. The Appellants appeal against the decision of Respondent made on 18th September 2014 to refuse to vary their leave to remain and to remove them from the United Kingdom by way of directions under Section 47 of the Immigration, Asylum and Nationality Act 2006. Their appeal was determined and dismissed by First-tier Tribunal Judge Pooler on 30th December 2014. Permission to appeal against that decision was granted and on 3rd November 2015, having heard submissions, I found that there was a material error of law in the determination of First-tier Tribunal Judge Pooler and I set his decision aside. Although I specifically granted permission in respect of the third Ground of Appeal I made it clear that it may well be the case that the reconsideration of the appeal would have to be wider than that probably intended by the Upper Tribunal Judge who granted permission, given that the medical investigations into AM's condition have not been completed and a more complete diagnosis and prognosis made other issues relative to the effect of removal on the Appellants and thus to the issue of stigmatisation and societal discrimination. What had been submitted in the third ground was that the judge had failed in relation to Article 8 to consider the impact on AM of the entrenched societal discrimination against suffers of epilepsy. The judge had made no findings in respect of evidence relating to the child's half-brother or in respect of the evidence contained in a medical report from Dr Adeshina relating to the stigma suffered by epileptics or in respect of the potential impact on AM's morale and physical integrity of any discrimination or stigma he may face in Nigeria. Judge Pooler had noted that there was "scant medical evidence" produced relating to the actual nature of the risk facing the child if he were unable to access appropriate medical treatment, a factor also relevant to the assessment of AM's private life under Article 8, i.e. his moral and physical integrity. There is evidence that AM's uncle, his father's half brother, also suffered from epilepsy and indeed had tragically committed suicide in Nigeria when he was 16 years old because of the difficulties he had endured there. There is a genetic element to the epilepsy which AM has. His mother's brother also suffered from it.

5. All three Appellants and the First Appellant's younger son appeared before me at the hearing.

Decision of the Secretary of State

6. The decision of the Secretary of State is contained in a letter dated 14th July 2014. She considered the application under paragraph EX.1 of Appendix FM of the Immigration Rules and under paragraph 276ADE(1). She considered the family and private life of the First Appellant. With regard to the children she considered whether leave should be granted under Appendix FM as a child. She considered the Article 8 rights of the children and with regard to the elder child said that Section 55 of the Borders, Citizenship and Immigration Act 2009 had been considered. The Secretary of State took into account that the family would all be returning to Nigeria together so there would be no breach of their family life. The Secretary of State took into account that the elder child suffers from epilepsy and took into account the letter from Dr Adeshina which said that the availability of treatment for epilepsy in Nigeria is not as good as it is in the UK. The view of the Secretary of State is that treatment for epilepsy is available according to the Country of Origin Information Report. The Secretary of State said that whereas it is accepted that healthcare systems in the UK and Nigeria are unlikely to be equivalent this does not entitle the Appellant to remain here with his child.

7. I have a statement prepared by the First Appellant for the resumed hearing before me. I would say that at the hearing on the issue of error of law I was given some information about the child and his condition. Having heard that, I asked the First Appellant and his wife to prepare statements and I now deal with these. The First Appellant set out his immigration history in the UK. With regard to his elder son he said the following. The child is now 8 years old. He entered the UK on 17th October 2009. He has been diagnosed with complex partial epilepsy. He had his first seizure on 29th August 2012 and since then he has been having seizures on a regular basis. He is under the care of Dr Siobhan West, a Consultant Paediatric Neurologist at the Central Manchester Hospital. The First Appellant states that he has witnessed how epileptics are treated in Nigeria as two members of his family were epileptics - his half-brother [OO] and his mother's only brother [KF]. [OO] suffered from epilepsy from the age of 6 until he committed suicide on 15th September 1992 at the age of 16. He said he was aware of his mum and dad taking his brother to different traditional homes in an attempt to find a cure for his condition. [OO]'s education suffered greatly as a result of his condition. The First Appellant states that although he was only about a year and a half older than him he was five years ahead of him in terms of school years as a result of his younger half-brother having to change school from time to time coupled with him having seizures during exam times. He was made to repeat classes many times. He would often suffer epileptic seizures on his way to and from school and the First Appellant would stand beside him powerless as other students gave them insults and abuse. He would stay with his half-brother until he regained consciousness and both of them would cry and go home. His half-brother had to drop out of school because he could not bear the shame and abuse from the other students and teachers. He said in his suicide note that he had to go so that his parents and siblings could be free from the shame that was all due to him. He said he received love and care from his family but hated discrimination, stigmatisation and shame each time he went outside the home. The First Appellant states that it

was the most horrifying experience of his life. He recalls how one day one of his father's friends came to the house and told his dad about a man he claimed had the power to cure [OO] of his epilepsy. His dad was reluctant to go because he had taken him to several herbalist homes and churches. However [OO]'s mum prevailed on his dad urging him to give the man a try. They were there for seven days. When they came back [OO] had marks all over his body. The man had used a razor to cut his face, back, hands and legs and applied some black powdery substance to him. They claimed that this would chase away the evil spirit responsible for his condition. The First Appellant goes on to say that stigmatisation, discrimination and inhumane treatment of epilepsy sufferers are a very big issue in Nigeria. His son's teachers now know what to do when he has a seizure because his epilepsy nurse [MD] has given the school a care plan on how to manage his epilepsy. In Nigeria he would get no such help. He recalls one day he went out with his half-brother about a couple of days before he died. He had a seizure on a bus and everyone on the bus came down. Some were insulting and abusing them and others were kicking them. He has been very badly affected by this.

8. He then speaks of his uncle saying he suffered from epilepsy until he died in 1996 at the age of 29. He too experienced a lot of discrimination and dehumanisation. He dropped out of school in primary 4 at the age of 14. His mother had to juggle raising five boys with caring for her epileptic brother. She would take him from one church and traditional home to the other in search of help.

9. The First Appellant states that his son's education is getting stronger and stronger in the UK despite his condition and this is only possible because of the difference in cultural beliefs regarding people suffering from epilepsy and other mental disorders. Whilst epilepsy sufferers in Nigeria are moved from one church or herbalist home to another in the hope of finding a cure or confined to the four walls of their home without hope for the future, their British counterparts are supported to lead a normal life and achieve their potential through the provision of good medical care, adequate care plans and constant review and management of their condition. He goes on to name many British people who have achieved great things despite being sufferers of epilepsy. He worries that his son would not be able to fulfil his potential in Nigeria. His welfare would not be safeguarded and promoted. He would be maltreated, discriminated against and stigmatised. He says that as his parents he and his wife have the burden to prevent impairment of his health and total development. They have a responsibility as parents. He would be alienated in Nigeria. It would be worse for his son because he has now experienced in the UK the levels of care and understanding relating to his condition. He could not understand why he was being so badly treated. He points out that he and his wife have a good immigration history.

10. In her statement the Appellant's mother says that her elder son was very healthy until he had his first seizure in August 2012. They had had no problems prior to that. When it happened they were in church. The child turned floppy and was turning his head from one side to the other. His eyes were rolling backwards. The pastors, elders and medical practitioners in church attended to him and after a few minutes

he became conscious. About four weeks later the same incident happened again in church. The following day they went to their GP and he referred them to a paediatrician. The first time the child had an epileptic episode in school he was rushed to A & E by ambulance. The doctors asked if there was any history of epilepsy in the family. She said there was not but her husband said there was history in his family. His younger brother committed suicide. The child had a seizure one day when the First Appellant's mother was staying with them on holiday. She got help from the neighbours to call an ambulance and she spoke of how she had had to move her brother from one place to the other in search of a cure. She also spoke about her stepson and how he committed suicide. She was extremely upset about the child's condition. The child has now had several epileptic episodes at school. He is well looked after by everyone at his school and is very popular. He has won lots of awards for his good work ethic and helping colleagues. His school has written two letters supporting their immigration case. She is worried that his education will suffer if he is returned to Nigeria and that society would not give him the opportunity to thrive. The child also engages in extracurricular activities like swimming, football and going for guitar lessons. The medical professionals treating the child have said that they have to let him enjoy whatever he wants to do as long as they are looking out for him. This is a contrast to what would happen in Nigeria. She says that when she took the child to register him for a swimming class she was asked about medical conditions and told the teacher that he is epileptic. She became upset but the teacher told her not worry and that she would look after him and make sure he had fun. She says everyone has been amazing. She says that when the child had the first seizure they were just one month into their two year post-study work visa. They did not plan for this to happen. They would not have wished it on their child just so that they can remain in the UK.

The Medical Evidence

11. I have before me medical evidence as follows:-

    (i) A letter from Dr Siobhan West at Central Manchester University Hospitals dated 4th November 2015. She says that she first met AM in June 2013. She had diagnosed focal epilepsy. He has had an MRI scan, a standard EEG and a sleep EEG. The MRI scan was normal and did not show any focal changes that could be a cause of the epilepsy. He has been on anti-epileptic medication since September 2013. The first medication that he was given did not make any difference to his seizures and he was subsequently tried on another in September 2014. He is apparently still having seizures albeit infrequently which suggests that his current treatment is not controlling the condition. She states that there are many other medications that she would consider trying him on. The ideal solution would be to find the medication that could control all his seizures and render him seizure-free. The chances of this happening having already tried to types of medication is low. If he continues to have the seizures she will consider doing a further MRI scan which is more detailed. He has to be older to have this as he cannot have it with sedation or general anaesthetic. She had been asked to comment on what would happen if his condition was

untreated. Her response is that she would expect him to continue to have seizures but it is impossible to determine how frequently these would occur. The seizures are unpredictable in nature and this in itself causes stress to the child and to his family as they may occur when he is in a position that could be dangerous. When AM has seizures his eyes deviate to the right, his head deviates to the right and he becomes unsteady on his feet. He feels odd prior to this starting so knows something is going to happen. The events last a minute or two and then he is sleepy afterwards. It seems as though the seizures are originating from one particular part of the brain. A further more detailed scan may show an area that has some cortical dysplasia i.e. an area of the brain that has not formed properly that is the trigger for these events. If that is the case then sometimes epilepsy surgery can be an option to cure the epilepsy. This has not at this point been discussed with the family.

(ii) A letter from Dr West dated 1st May 2014 stating that the Appellant is undergoing investigation for partial epileptic seizures.

(iii) A letter from Dr Tan, a Consultant Paediatrician at North Manchester General Hospital dated 10th September 2013 addressed to Dr West. This is in relation to investigations he was carrying out. He states:-

> "According to previous letters he had two EEGs in November 2012 and December 2012 which were both reported as normal. His sleep study on 6th November 2012 reports moderate severe obstructive sleep apnoea with 140 desaturation with lower set at 78%. He was therefore listed for urgent adenotonsillectomy in RMCH. Mother reports that he had a further floppy episode at home in July 2013. This happened when he was playing on his Wii when complaining of feeling dizzy and becoming floppy. His mother had to assist him going to bed. During this episode he appeared to be responsive when he was talked to then he turned his head to the right and his mother was unable to move his head into midline. This lasted for about five minutes. There was no stiffness in his arms or legs reported.
>
> In conjunction with his abnormal report ambulatory EEG I would be most grateful if you could review him for further management. I also noted that he has not according to our records any cranial imaging in the past and judging from his behaviour in the past two clinics I have seen him I suspect he may need an MRI. If he needs an MRI scan this requires to be under general anaesthetic."

(iv) A letter dated 17th December 2012 from Dr Puri, an Associate Specialist. He states that AM was at the clinic on 17th December 2012 for follow-up examination. He had earlier been admitted from 5th November 2012 to 7th November 2012 for an unresponsive episode/seizure and moderate obstructive sleep apnoea. He had had an episode at school witnessed by the teacher. He complained of chest pain prior to it. There as no tongue-biting or incontinence. He was admitted for observation and investigation and had no

further unresponsive episodes whilst in hospital. He had been reported to have had two floppy episodes one in August and the second on 23rd September 2012. He was admitted on 24th September 2012 for observation and given the impression of a fit/migraine. He had an EEG on 6th November 2012 and one on 4th December 2012 which was reported within normal limits. There had been an episode the day before when he complained of pain in the abdomen and became weaker and floppy. This episode lasted about ten minutes. It is noted that his teachers describe him as "a brilliant boy". It is noted in this report that there was family history of fits.

(v) A letter from Dr Kayode Adeshina, a Consultant Paediatrician in Lagos. He was asked to provide some information about the treatment of people suffering from epilepsy in Nigeria and also to comment on the effect there would be on a 6 year old child returning to Nigeria suffering from complex partial epilepsy. He states the following:-

> "Epilepsy is a complex disorder that requires specialised knowledge for correct diagnosis, classification and treatment. It is estimated that in Nigeria over 3,600,000 people suffer from epilepsy and over 80% of people with epilepsy do not receive any form of treatment or care. Nigeria does not have a protocol for the treatment of epilepsy. There is no cohesive programme for identifying and treating patients with epilepsy. There is no clear statement on who should be responsible for the treatment whereas in many developed countries neurologists and epilepsy specialists are charged with that responsibility. On paper there are anti-epileptic drugs which can be taken by sufferers to reduce the incidence of seizures but the truth is that drugs are not readily available. Effective management of epilepsy demands that preliminary tests should be carried out to establish the right drug and also while medication is still ongoing proper and thorough investigation is required to move to the next level in care management. There are no facilities to do this in Nigeria. Neuro-imaging which is an essential requirement for effective diagnosis and treatment is not available and as a result sufferers who can afford to travel abroad do so. Recent statistics show that Nigeria has about 50 neurologists which means one neurologist is 'responsible' for treating 72,000 epileptic patients alongside patients with other forms of neurological disorders. He says 'for epileptic patients in Nigeria the picture is gloomy with no hope of succour'."

12. Dr Adeshina goes on to say that people in Nigeria still believe that evil spirits are responsible for epilepsy. Another issue is that it is common practice for relatives of epileptic sufferers to seek help from traditional herbalist homes and churches but because the majority of Nigerians and indeed Africans believe that epilepsy is due to a spiritual attack and that the demon must be cast out of the patient, many patients have been subjected to massive cruelty and even death. Demons have been thought responsible and therefore herbalists homes try to beat it out of sufferers. Social attitudes towards epilepsy can cause more distress to patients and the relatives than

the disease itself. They believe that epilepsy is infectious and transmissible through saliva. This adds a social and economic burden to the physical burden of illness. There have been many instances where sufferers have been stoned while convulsing in public places. Some communities burn the feet of a sufferer during convulsion while others give concoctions such as urine, alcohol etc. As a result of this social stigma school attendance and academic performance of children as well as adolescents suffering from epilepsy have been negatively affected. Children with epilepsy are highly stigmatised and discriminated against by fellow students and by teachers. In fact society does not protect sufferers and schools have a way of discriminating against them for admission and where it is discovered post-admission the schools tactically find a way to expel such children because of the belief that the disease is infectious. It is estimated that over 36% of children with epilepsy in Nigeria have never attended school and about half of those who attend school withdraw prematurely because of their seizures and the associated shame. Some patients have committed suicide because they cannot cope with the treatment meted out to them by the public. He concludes that there is no cure for AM in Nigeria. He has a genuine fear that he would suffer the same fate as many others and that his interests would be best served by receiving treatment in the UK most especially to protect his education as he has been made to understand that he is a very intelligent boy. He concludes:-

> "Until the Nigerian Government makes a conscious effort to help people with epilepsy not only in the area of care and management of the disorder but also into the area of general awareness and reorientation of the Nigerian public to debunk the myths and misconceptions around the disease epilepsy in Nigeria will continue to be a dark, lonely and silent world of shame."

13. In his submissions Mr McVeety conceded that there are no credibility issues. He relied on **Zoumbas [2013] UKSC 74**. He accepted that the Appellants have always been here lawfully and that this is not a case where there has been "health tourism". He submitted that family support is available. He asked me to take into account paragraph 117B of the 2002 Act. He said that the issue here is purely one under Article 8 ECHR.

14. I have a skeleton argument which was prepared by Ms Mair. She points out that the Appellants have always lived lawfully in the United Kingdom. They have always remained in compliance with the Immigration Rules. She cites case law in support of her submission that there are circumstances in which the high threshold for Article 8 in health cases may be lower where children are involved. She points out that a final diagnosis has not been made with regard to the child. He benefits from the intervention of a specialist epilepsy nurse at school. There is a letter from the head teacher dated 25th June 2015 expressing his concern at the possibility that the child may no longer be able to attend school or stay in England given that he has complicated medical needs that need care, attention and medical expertise. He says that they have at the school witnessed three epileptic attacks during school time over the past six months. She asks that I take into account the evidence of the Appellant's

parents and of Dr Adeshina on difficulties for people suffering from epilepsy in Nigeria. She asks that consideration be given to the following matters:-

(i) The likely extent and severity of the child's seizures and epilepsy if removed without his condition being fully diagnosed and treated.

(ii) The consequences of such seizures and disability on the child's life chances, welfare and best interests.

(iii) The extent of discrimination and stigma that the child may suffer as a consequence.

She goes on to submit that in particular these issues must be considered against the background of the child's achievements and his life chances in the UK such as schooling, societal discrimination and societal abuse. She points out that at school in the UK he is performing above age-related expectations whereas in Nigeria the evidence is that he most likely would not finish his schooling and would be likely to suffer discrimination and potential exclusion. He suffers no discrimination in the UK. The level of stigma and discrimination would affect a child much more than an adult. He would not get treatment in Nigeria. He will have lived in the UK for seven years on 17th October 2016 and in those circumstances there would have to be strong reasons for justifying his removal from the UK under paragraph 276ADE(1)(iv). The policy guidance on considering the best interests of a child when determining an application under Appendix FM states that the longer the child has resided in the UK the more the balance will begin to swing in terms of it being unreasonable to expect the child to leave the UK and strong reasons will be required in order to refuse a case with continuous UK residence of more than seven years. The decision maker must consider whether in the specific circumstances of the case it would be reasonable to expect the child to live in another country. The child does not yet have seven years' residence but there are other considerations and the guidance says that relevant considerations are likely to include whether there would be a significant risk to the child's health, for example if there is evidence that the child is undergoing a course of treatment for a life threatening or serious illness and treatment will not be available in the country of return. Another consideration is whether the child is likely to be able to integrate readily into life in another country. The difference in health and education facilities will not normally be a relevant consideration particularly if the parents have the means or resources to support the child but there may be exceptional circumstances which would mitigate against this. The parents are putting this case squarely on the grounds that owing specifically to the child's disability he would potentially be barred access from education and owing to discrimination, would be prejudiced in terms of his social development. She cites **SS (Nigeria) v SSHD [2013] EWCA Civ 550** in which the Court of Appeal said:-

> "None of this, I apprehend, is inconsistent with established principle, and the approach I have outlined is well supported by the authorities concerning the decision maker's margin of discretion. The leading Supreme Court cases **ZH**

and **H(H)** demonstrate that the interests of a child affected by a removal decision are a matter of substantial importance, and that the court (or Secretary of State) must proceed on a proper understanding of the facts which illuminate those interests."

15. In her submissions Ms Mair said that AM has not responded to the two drugs he has been given up to now. There are newer experimental drugs which are not available in Nigeria. Even the usual common drugs are not readily available. If these experimental drugs are to be tried by Dr West there will be some years of experimentation. The child also needs a scan which cannot be done while he is so young. Ms Mair said it is possible that no proper diagnosis will ever be made. Curative surgery may be possible but this would not be available in Nigeria. Diagnosis and cure are only available in the UK and not in Nigeria. Without treatment the seizures will continue. There are special circumstances in this case in that the half-brother of the First Appellant killed himself because of the abuse he suffered as an epileptic. He wants to protect his child from this. He also wants to protect his younger son. It would be difficult for the First Appellant to go back to Nigeria where his brother suffered so and committed suicide. He had left a suicide note explaining why he had done what he did. Ms Mair submitted that one of the crucial factors in this case is the education of the child. The letters from the school are very helpful. The school is dealing exceptionally well with the situation. The evidence is that in Nigeria he would be likely to be excluded. He would certainly not get the level of understanding and assistance that he is getting in the UK. She referred me to **GS (India) v SSHD [2015] EWCA Civ 40.** The First Appellant has been here for nine years. He has studied and worked here. The family are financially self-sufficient and fluent in English.

My findings

16. I have carefully considered all the evidence put before me and I proceed to consider that evidence in terms of Article 8 ECHR. The effect of removal on the child AM is the basis on which this appeal has been made. I take account of the public interest factors set out in s. 117B of Nationality Immigration and Asylum Act 2002 and I give weight to the fact that the family have always been in the UK legally and lawfully, that the First Appellant has been here for nine years and that the child AM has been here for over six years. The family speak English and are financially self sufficient. The First Appellant is in employment and has a contribution to make to the economy and to society.

17. In **Razgar, R (on the Application of) v. Secretary of State for the Home Department [2004] UKHL 27 (17 June 2004)** the court said that there are 5 questions that must be asked in considering the question of a breach of Article 8,

(1) Is there an interference with the right to respect for private life (which includes the right to respect for physical and moral integrity) and family life?

(2) If so, will such interference have consequences of such gravity as potentially to engage the operation of Article 8?

(3) Is that interference in accordance with the law?

(4) Does that interference have a legitimate aim?

(5) Is the interference proportionate in a democratic society to the legitimate aim to be achieved?

18. There is of course a family life but I accept that as the family would all be removed together there would be no interference with that family life. Mr McVeety on that point rightly relied on **Zoumbas**. It is also clear from current caselaw and in particular from **GS** that the fact that there is better medical treatment and in the UK than there is in Nigeria is not a factor that does in general engage Article 8. Indeed the findings in **GS** were unequivocal on that point and left very little room for manoeuvre. The Courts have however said that the test for children is not so strict and cases involving children must be considered differently and carefully, the starting point being what is in the best interests of the child. The Secretary of State is of course bound by s55 of the Borders Citizenship and Immigration Act 2009 to consider in every case the best interest of any child affected by her decision.

19. In **MK (best interests of child) India [2011] UKUT 00475 (IAC**) the Tribunal said,

> (*i*) The best interests of the child is a broad notion and its assessment requires the taking into account and weighing up of diverse factors, although in the immigration context the most important of these have been identified by the Supreme Court in ZH (Tanzania) [2011] UKSC 4, the Court of Appeal in AJ (India) [2011] EWCA Civ 1191 and by the Upper Tribunal in E-A (Article 8 –best interests of child) Nigeria [2011] UKUT 00315 (IAC).
>
> ii) Whilst an important part of ascertaining what are the best interests of the child is to seek to discover the child's own wishes and views (these being given due weight in accordance with the age and maturity of the child) the notion is not a purely subjective one and requires an objective assessment.
>
> iii) Whilst consideration of the best interests of the child is an integral part of the Article 8 balancing exercise (and not something apart from it), ZH (Tanzania) makes clear that it is a matter which has to be addressed first as a distinct inquiry. Factors relating to the public interest in the maintenance of effective immigration control must not form part of the best interests of the child consideration.
>
> iv) What is required by consideration of the best interests of the child is an "overall assessment" and it follows that its nature and outcome must be reflected in the wider Article 8(2) proportionality assessment. Consideration of the best interests of the child cannot be reduced to a mere yes or no answer to the question of whether removal of the child and/or relevant parent is or is not in the child's best interests. Factors pointing for and against the best interests of the child being to stay or go must not be overlooked.
>
> v) It is important when considering a child's education to have regard not just to the evidence relating to any short-term disruption of current schooling that will be

caused by any removal but also to that relating to the impact on a child's educational development, progress and opportunities in the broader sense.

20. Clearly it is in the best interests of AM to remain in the UK and continue with his medical treatment here but given what was said in GS, even taking a softer approach to children, this of itself is arguably not sufficient to render the decision to refuse leave disproportionate. As was said in **MK** what is required is an 'overall assessment'.

21. In making an overall assessment I can do no better than begin by adopting the submissions of Ms Mair and I so do. There is no adverse immigration history and the Appellants are self sufficient. AM has been in the UK for over 6 years. He has been attending school here. He has fairly recently been diagnosed with epilepsy but a final diagnosis has not been made and cannot be made until he is old enough to undergo the required scan. It may well be that some basic treatment is available in Nigeria but it appears from the evidence before me that the likelihood of more advanced diagnosis and treatment is small. It is possible that the child would be left with only the treatment he is currently having which is not working. He has been given the expectation of further investigation and treatment and he would lose that if removed.

22. Just as important is the fact that this is a young child, diagnosed with what must be a very frightening illness for a child, who has had so much support from his school as well as from medical professionals. His teachers have a plan for dealing with his episodes. They know what to do. He will have come to know that they know what to do. He knows he will be safe and cared for. To take that away from him would be devastating. He has suffered no stigma or discrimination. No one has told him he will have limited prospects in life or that he cannot go to school. No one has suggested he is any different to any other child. This is not a situation where he previously lived with his epilepsy in Nigeria. He knows only what he has experienced in the UK. I was told he is a clever and hard working child who will have a good future in education in the UK. The evidence before me suggested that that would not be the case in Nigeria and the Respondent put nothing before me to refute that.

23. The evidence of the difficulties for sufferers of epilepsy in Nigeria is strong and shocking. I accept the evidence of AM's father and I accept that the death of his half brother and indeed the treatment he witnessed will have affected him badly. I formed the impression that he and his wife are finding it hard to deal with their son's epilepsy because of the past and their fears of what he would endure in Nigeria. The First Appellant has long lived under a shadow caused by epilepsy. I also take into account that AM has a younger brother who may also have to deal in his childhood with discrimination and societal stigma against his brother in Nigeria.

24. Having considered the overall situation of the family and the best interests of AM and indeed his brother, I find that in all the circumstances the interests of AM

outweigh any public interest in the removal of the family from the UK and I find that their removal would be disproportionate.

Notice of Decision

The appeals are allowed on human rights grounds.

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

Unless and until a Tribunal or court directs otherwise, the Appellants are granted anonymity. No report of these proceedings shall directly or indirectly identify them or any member of their family. This direction applies both to the Appellants and to the Respondent. Failure to comply with this direction could lead to contempt of court proceedings.

Signed   Date: 29th February 2016

N A Baird
Deputy Judge of the Upper Tribunal