



Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: DA/00449/2013

THE IMMIGRATION ACTS

Heard at Field House
On 24th April 2018

Determination Promulgated
On 21st May 2018

Before

UPPER TRIBUNAL JUDGE LINDSLEY

Between

P F

(ANONYMITY ORDER MADE)

and

Appellant

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr A Mahmood, of Counsel, instructed by AM International Solicitors

For the Respondent: Mr S Kotas, Senior Home Office Presenting Officer

DECISION AND REASONS

Introduction

1. The appellant is a citizen of Nigeria born in 1977. He arrived in the UK in 1990 with his younger sister when he was 13 years old. He stayed with his older sister who already lived in the UK as student, and on 30th March 2000 he was granted indefinite leave to remain.

2. On 3rd September 2010 he was convicted of conspiracy to supply a controlled drug class A and sentenced to five years and eight months imprisonment: this was the index offence which led the respondent to make a decision to make a deportation order on 13th February 2013 under s.32(5) of the UK Borders Act 2007. The appellant appealed against the decision to deport him and this appeal was allowed on human rights grounds by the First-tier Tribunal in a decision dated 10th July 2013. However, the decision was found to contain errors of law, and was set aside and the remaking remitted to the First-tier Tribunal in a decision of a Presidential Panel made on 12th February 2014.
3. On 21st March 2017 the appellant was convicted of a further offence of conspiracy to supply a controlled class A drug and was given a further custodial sentence, this time of four years imprisonment.
4. His appeal against the decision to deport was reheard and dismissed by First-tier Tribunal Judge Metzger in a determination promulgated on the 6th June 2017.
5. Permission to appeal against the decision of First-tier Tribunal Judge Metzger was granted by Upper Tribunal Judge Perkins on 1st November 2017 on all grounds on the basis that it was arguable that the First-tier judge Metzger had erred in law in failing to properly apply the decision of the European Court of Human Rights decision in Paposhvili v Belgium 13th December 2016 ECtHR given that it was arguably accepted by the First-tier Tribunal that the appellant suffers from sickle cell anaemia and that he would not be able to access treatment for this in Nigeria.
6. The matter came before a panel of The Right Honourable Lord Boyd of Duncansby, sitting as an Upper Tribunal Judge and myself, Upper Tribunal Judge Lindsley, to determine whether the First-tier Tribunal had erred in law. We concluded that there had been an error of law for the reasons set out in our decision at Annex A.
7. The matter now comes back before myself alone, pursuant to a transfer order, to re-make the decision. As a result of an enlargement of arguments by the appellant, a lack of clarity in relationship to important facts, and a key document being missing I gave post-hearing directions to both parties, and reserved my decision so that this information could be before me at the time of making of the decision on the appeal. These directions are attached as Annex B, and I confirm that I received and considered information on all issues requested.

Evidence & Submissions – Remaking

8. I set out the evidence presented at the hearing in summary only. I heard oral evidence from the four witnesses as set out below, but not from the appellant who is in serving a prison sentence: it was decided by his legal team that it was not necessary to call him to give evidence.
9. The first witness was Ms AO. She came to the UK in 1983 and is a naturalised British citizen, and the appellant's older sister. She confirms that the appellant came to the UK with one of her younger sisters in 1990 and has lived here ever since. He came

to live with her, and was present throughout his secondary schooling. In about 1995 the appellant met Ms MB and had an on/off relationship which led to the birth of his daughter CF in May 1996. The appellant has however had a constant input into CP's life. In 2005 the appellant met MP, who is his current partner (although they did break up at one point). They have a daughter AF born in February 2007, and MP has an older son AC born in April 2001 from a previous relationship who is part of their family unit. MP and the appellant are engaged to be married. The appellant also has a son RF born in February 2015 from a short relationship with KT, and the appellant is committed to bringing up this son too.

10. AO believes it allowed to remain in the UK that the appellant might be able to work in his own business and will behave well and rehabilitate.
11. If deported AO believes that the appellant will not survive in Nigeria. This is because he has severe sickle cell anaemia which means that he needs constant medication and medical monitoring; is in and out of hospital; he has pain in his joints which is so intense that he collapses when he has a sickle cell crisis and then needs family members such as herself to do everyday tasks; and from time to time he also needs blood transfusions. In Nigeria the only family members left are the relatives of her mother's sister, her maternal aunt, (who is 75 years old) and they are not close or willing to assist the appellant. She did not see this family when she last went to Nigeria for a friend's wedding.
12. AO explained that the appellant's mother had not been able to attend the hearing because she was unwell with arthritis. She herself had not visited the appellant recently in prison due to her own health problems but was aware that his partner and children had done so. AO last saw the appellant in court in 2016.
13. KT sets out that she is a British citizen and had a short relationship with the appellant in 2014/2015 from which she had her son, RF, who was born in February 2015. She confirms the appellant has spent a lot of time with RF and that she wants him to be part of RF's life as RF loves him. Prior to being imprisoned in May 2016 the appellant took RF to be part of his extended family with his mother, partner and siblings. They are all on good terms. She has continued to take RF to see the appellant in prison, and last visited in March 2018. She would not be able to take RF to Nigeria, a place she has never been to and so her son's relationship would be lost if the appellant is deported. She had only found out about the appellant being subject to deportation proceedings after she was pregnant with RF.
14. MP gave evidence that she is a British citizen of Jamaican origin and has been in a relationship with the appellant since 2005. They have a daughter, AF, born in 2007 and the appellant has taken a parental role with her older son, AC, who was born in 2001. AC has ADHD and learning difficulties: the appellant has helped her with him a great deal. The family are all supportive of each other, and she spends time with the appellant's mother, siblings and ex-partner MB who is mother of his older daughter CF.

15. MP visits the appellant in prison with her children every other month, and last went to see him three weeks ago. The appellant also keeps in touch by phone calls, letters and DVDs with voice messages. In the period of their relationship the appellant has had two substantial periods of imprisonment, one in 2010-2013, and the other from March 2017. During the first one her mother had been able to help her with the children as she was not working but this is no longer the case.
16. MP gave evidence that the appellant, when not in prison, has enable her to work full-time. He has a strong loving relationship with all four of the children. She and the appellant are engaged to be married. She says that her children have both been visibly anxious since the appellant was last arrested. She has anxiety, insomnia and symptoms of depression and is taking medication as a result of the situation with the appellant and his imprisonment and deportation. She has also had calls from his older daughter CF where she has been crying on the telephone.
17. MP says that the conviction in 2015 for driving whilst disqualified took place in exceptional circumstances as he was stabbed and drove himself to hospital out of fear due to his sickle cell condition. She cannot explain the appellant's other reoffending behaviour, but she knows he is truly sorry. She feels that he will not offend again as he is now a changed and broken man.
18. MP says that to deport the appellant to Nigeria would be to impose a death sentence on him. His sickle cell anaemia means that he has constant crises and need constant medication. She says he takes about five different medications some of which are vitamins and the rest painkillers. When he has attacks his joints become so painful that he collapses and needs medical treatment at hospital and then family care. In February and March 2018 for instance the appellant had flare ups of his medical condition and had to take painkillers and rest, and he will have more medical check -ups this month. He is not just taken to the Homerton hospital as he will attend whichever is the local hospital when in pain. She felt he went to hospital about 10 times a year. Sometimes he has had to have morphine injections for the pain. His condition also gets worse in the heat. She is aware of this as they once tried to take a holiday in Barbados and he became unwell. There is not the relevant medical treatment available in Nigeria according to the experts and no family to assist him if he has a flare up there. He needs help to be taken to hospital in these circumstances and to be looked after and there will be no one to do this in Nigeria as she cannot relocate with her children to that country. The family does not have means to pay for private care.
19. CF gives evidence that she is the adult daughter of the appellant born in the UK in May 1996, and is a British citizen. She has a degree in psychology from the University of Coventry. Her parents separated in 2001 but she has always had a very close relationship with the appellant, and when he has not been in prison has spent every other weekend with him. She feels he understand her better than her mother. She does not believe that the appellant has any family in Nigeria to turn to look after him when he is sick. She believes that the 2015 driving conviction was a mistake due to his being stabbed and wanting to get to the hospital and not

understanding the length of his driving ban. She believes that if allowed to stay that the appellant would not jeopardise his family again by engaging in criminality.

20. CF has very recently given birth to a daughter, CT, born in March 2018, and will be visiting the appellant with her in April 2018. The birth of CT means there is no way that she could accompany the appellant to Nigeria which is a place she would have no way of finding employment or accommodation or living. She has struggled with depression and was briefly on medication due to the situation with the appellant, and she knows that his daughter AF is also worried and sad.
21. CF is very concerned that the appellant will not be able to care for himself if he is deported. Her evidence is that he gets sick every 3 or 4 weeks, and when he is in a crisis needs help from family members such as herself with basic tasks such as getting food and going to the toilet, and doing to the hospital if the pain he suffers cannot be managed with painkillers. She believes he won't have this help in Nigeria and this causes her to dread what will happen. She knows that the appellant is very frightened too as she has seen this when she has visited him in prison.
22. The appellant's documentary evidence is set out in two arch-leaver bundles and consists of medical evidence about the appellant's sickle cell and other medical problems; evidence about the availability of medical treatment in Nigeria; evidence about the appellant's qualifications from prison, his sentence plan and his OASys report; and statements, birth certificates and statements from the appellant and his family and a psychological report on the children. I will refer to this evidence, where relevant, in my conclusions but it has been considered in its entirety in the making of this decision.
23. Following directions further evidence was submitted by the appellant. Mr Kotas has objected to the inclusion of the email letter of 4th May 2018, which is a letter from a friend who lost his sister to sickle cell disease in 2015 in Nigeria, as there was no application for the appellant to be permitted to include this document, and that little weight should in any case be given to such an opinion. I accept that it would not be appropriate to give weight to this letter in all of the circumstances, particularly as those representing the appellant have not responded to this position from Mr Kotas in the reply document dated 15th May 2018.
24. Mr Kotas relied on the reasons for refusal letter and his skeleton argument and submitted that the appeal should be dismissed for the following reasons. In relation to Article 3 ECHR Mr Kotas submits that AM (Zimbabwe) & Anor v SSHD [2018] EWCA Civ 64 is not authority that the law relating to Article 3 ECHR has changed. In that case it was agreed that the law relating to that issue was still to be found in the decision of N v SSHD UKHL [2005] 31. The Court of Appeal issued guidance only to assist courts and tribunals deal with stays of removal. The guidance provided was that a stay would be justified if the test at paragraph 183 of Paposhvili can be met. As a result AM (Zimbabwe) does not change the ambit of Article 3 ECHR in a statutory appeal.

25. Even if this argument is not accepted it is contended for the Secretary of State that the appellant does not cross the line for making his removal unlawful on Article 3 ECHR grounds as set out in Paposhvili because that threshold is still exceptionally high, requiring “the imminence of intense suffering or death in the receiving state, which may only occur because of the non-availability in that state of the treatment which had previously been available in the removing state”, and the Grand Chamber noting it was only making a modest extension of Article 3 protection; and that disparity in healthcare is not a benchmark and the existence of an interior healthcare system in the receiving state does not suffice. Finally, it is noted that there was only a finding by the Grand Chamber in Paposhvili that the removal of the applicant would have been a breach of the procedural obligations under Article 3 ECHR if that had been done without looking at the applicant’s credible medical evidence.
26. Mr Kotas contends that relevant treatment is available for the applicant in Nigeria as set out in the reasons for refusal letter. The information in the reasons for refusal letter comes from the January 2012 Nigeria Country Report, which in itself relies upon sources of information from February 2010 (an interview with the Director of the Sickle Cell Foundation of Nigeria), from June 2010 (a news paper article from the Daily Independent We Rank Highest in Sickle Cell Disease – Minister Observed) and 2005 (a Nigerian Ministry of Health National Malaria Control Anti Malarial Policy). The information indicates that there are some free drugs and some hospital facilities, and some prophylactics against malaria which is widely recognised as increasing risk of sickle cell crisis. It notes that the Ministry of Health is trying to combat the situation where Nigeria has the highest annual sickle cell infant death rate in the world, with attempts to screen and diagnose sickle cell in adults and new-born babies. It is also noted that the appellant, by his own evidence, did receive some treatment of sickle cell when he lived in Nigeria as a child.
27. Mr Kotas argues in addition that the appellant is not acutely ill but has a life-long unpredictable and sporadic medical condition. He argues that the appellant has not produced a comprehensive medical report giving a prognosis if he is deported. His deportation would not be the deportation of a seriously ill person, he simply has a genetic condition which leads to sporadic bouts of pain and hospitalisation. He has, in the past, been able to study, work, be a parent and go on holiday abroad to Barbados. Even when he becomes unwell he is not exposed to a serious, rapid and irreversible decline in his health resulting in intense suffering or a significant reduction in his life expectancy. He just needs medication and a few days of hospitalisation. In particular there is nothing irreversible in what happens to this appellant. Mr Kotas notes that from the schedule of blood transfusions the appellant has not had one for over six years, and so this is not a probable event which would need to happen on his return to Nigeria.
28. Mr Kotas concludes by arguing that the appellant is really complaining about disparity of treatment if returned to Nigeria and cannot meet any Article 3 ECHR test to remain in the UK.

29. In relation to Article 8 ECHR Mr Kotas submits that a structured approach relying on s.117C of the 2002 Act is needed, see NE-A (Nigeria) v SSHD [2017] EWCA Civ 239. He says that the Court of Appeal have repeatedly made it plain that simple separation from British children and a British partner will not constitute the very compelling circumstances, which that structured approach set out in the Immigration Rules and s.117C of the 2002 Act requires, see for instance LC (China) v SSHD [2014] EWCA Civ 1310 and SSHD v CT (Vietnam) [2016] EWCA Civ 488. Even though the appellant had indefinite leave to remain, his history of offending behaviour has imperilled his status and it should be seen as therefore having been precarious, and thus little weight be given to the appellant's private life ties with the UK, in accordance with AM(s.117B)Malawi [2015] UKUT 260. Similarly, it is not enough that the appellant does not have family and other ties in Nigeria.
30. The respondent accepts that the appellant has a genuine and subsisting parental relationship with his three British citizen minor children (RF, AF and AC) and that it would be unduly harsh for them to go to Nigeria. CF is now over the age of 18 years, and so whilst the appellant's daughter she is not a child. It is noted that the appellant has had two significant period of imprisonment which has interfered with his relationship with these children from 2010 to 2013 and from March 2017 to the present time, with a brief period in prison in 2016 too. During this time the mothers of these children have had to cope without the appellant's day to day assistance. It is also of relevance that RF was born when the appellant was already subject to a deportation order, and that the appellant's immigration status should be seen to have become precarious after the birth of AF and after he had taken on a parental role for AC.
31. Mr Kotas submits that the appellant should not be seen as being a low re-offending risk as is set out in OASys report. This was because the appellant clearly minimised his role in his latest offence and committed that offence even though deportation proceedings were underway. There are also issues of drugs and alcohol problems in the papers which create a further risk of reoffending. However, even if this low prospect of reoffending were accepted as the case this is not a factor of sufficient weight to constitute very compelling circumstances, see the decision in Danso v SSHD [2015] EWCA Civ 596.
32. In relation to the appellant's sickle cell condition it is argued that there is treatment available for this condition in Nigeria, for the reasons set out above in Mr Kotas's submissions on Article 3 ECHR. As a very large number of Nigerian citizens have this condition and are treated in Nigeria the fact that the treatment may not match that given in the UK is not an exceptional or compelling feature. Further the evidence from the appellant is not in the form of a consultant's report which sets out the appellant's treatment needs based on his current condition and historic interventions. This was the evidence the appellant needed if he wished to show return would be a death sentence and it is not there. The reports of Dr Amos and Dr Omojasola are not sourced, do not include a statement of duty to the court and make broad sweeping statements, and in the case of Dr Amos are not based on first-hand knowledge. They should not be given weight. Similarly, the report, Building

a Solid Health Care System in Nigeria: Challenges and Prospects by Eme O Innocent dated November 2014 does not advance the appellant's case.

33. The evidence as set out in the medical notes is that the appellant has not been admitted to hospital as often as the witnesses have claimed. He has only 22 admissions to the Homerton Hospital over the period of 16 years. The evidence overall suggest that his condition is managed largely by drugs, which are essentially painkillers, folic acid and antibiotics. It is also notable that he had a gall bladder operation in 2012 and that some of his problems prior to this may have been related to this and not to sickle cell anaemia. There is not much mention of blood transfusions in the notes. It is further of relevance that the appellant has managed to complete his schooling, take employment, help with his family members and childcare and commit crimes despite having sickle-cell anaemia which indicates it is not as debilitating as has been argued on his behalf.
34. Further return to Nigeria will not be to a completely strange country as the appellant lived there until he was 13 years old, and does have an understanding of Yoruba. He has qualifications and has work experience and could be expected to make his way in that country, where he does also have an elderly aunt and her family.
35. This is a case where the appellant has an exceptional poor criminal record and where there are no other matters which can meet the tests described in SS (Nigeria) v SSHD [2013] EWCA Civ 550 as a "very strong claim indeed" on in Chege (section 117D Article 8 approach) Kenya [2015]UKUT 165 as needing to be a case that is "powerful" or "irresistible". The appellant is a persistent offender with three custodial convictions over four years, and having committed one of these when on notice he was threatened with deportation proceedings. The appeal should therefore be dismissed.
36. Mr Mahmood relied upon his skeleton argument and oral submissions and submitted that the appeal should be allowed.
37. In relation to Article 3 ECHR Mr Mahmood states that the appellant's position has changed from that as at the error of law hearing as since that hearing the decision has been given by the Court of Appeal in the case of AM (Zimbabwe), and so the test is not that death must be imminent in the removal country, but now is enlarged to cover cases where there would be a real risk on return to the appellant "being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy", so now included are those who would be at real risk of imminent intense suffering or death in the receiving state which may occur due to lack of treatment which had been available in the removing state.
38. In relation to the appellant's medical condition it is argued that the appellant is struggling with his sickle cell in prison even though there is someone there all of the time to care for him, and examples can be seen of him recently in hospital in

crisis, for instance on 30th August 2017, and of his difficulty adapting to environmental variation (this time cold) see notes for November 2017 or heat and dust, see notes for August 2017. The appellant has a history of significant admissions to hospital and this is set out in his complete medical records which have been provided. It is submitted that it is likely that the gall bladder issues were related to his sickle cell condition in any case as the evidence is that sickle cell can affect virtually all major organs. Dr Abiola has provided an updated version of his report to show he still regards it as accurate. There is no possibility of the appellant getting family support in Nigeria, the only relative being an elderly aunt with whom this part of the family are not close, and thus his life is at risk and there is a real risk of intense suffering if he returns to Nigeria. In these circumstances the appellant is able to show he meets the Article 3 ECHR test.

39. In relation to Article 8 ECHR the appellant contends that a combination of factors come together to make this an exceptional case where the appellant is entitled to win on Article 8 ECHR grounds. They are as follows: he has been in the UK for most of his life since he was 13 years old; he is culturally and socially integrated; he speaks English; he has no real links with Nigeria and no home there; he is too unwell to work in Nigeria to support himself; he was granted indefinite leave to remain so was not unlawfully or precariously present; he has three minor children, an adult child and a grandchild, and a large extended family in the UK; he suffers from serious sickle cell disease which leads to numerous medical conditions affecting almost all body systems; there is insufficient treatment for this condition in Nigeria; the appellant's children would not be able to visit him in Nigeria; his reoffending risk is low according to OASys, and weight should be given to this report which is written according to an objective statistical formula and he has shown signs of his becoming a better person and showing he is remorseful through his activities in HMP Huntercombe and his own statement and the impressions of his partner and adult daughter CF; that Dr Fahy, clinical psychologist concludes that the appellant's deportation would be highly disruptive and upsetting his children (including his adult child CF) and they would struggle to comprehend why such a fate befell them or why the state had taken their father from them and become depressed and anxious, this position also being reflected in the letter from AF; and finally there are concerns about the welfare of the appellant's elderly mother as she has already lost one son (who died) and would be losing another and about the devastating impact on his partner and siblings.

Conclusions – Remaking

40. There is no doubt that the appellant is a foreign criminal under s.32 of the UK Borders Act 2007, henceforth the 2007 Act, as he is not a British citizen and has committed criminal offences for which he was sentenced to a period of imprisonment of at least 12 months, and that as a result in accordance with s.32(4) of the 2007 Act his deportation is conducive to the public good and in accordance with s.32(5) of the 2007 Act the respondent must make a deportation order in respect of him. The question before me is whether s.33(2) of the 2007 Act provides

that these provisions do not apply however as his removal would breach any protection he is entitled to under the European Convention on Human Rights.

41. It is agreed by both parties that there are two routes by which this appeal might theoretically succeed because there might be a human rights exception to the appellant's deportation. The first route is for the appellant to show that his deportation would bring about a real risk of a breach of Article 3 ECHR on medical grounds. The second route would be by the appellant showing on the balance of probabilities that there are very compelling circumstances over and above the Article 8 ECHR exceptions to deportation set out in s.117C(4) and (5) of the 2002 Act, leading to a conclusion that his deportation would be a disproportionate interference with the private and family life rights of the appellant and his family.
42. For the appellant to succeed on Article 3 ECHR grounds the only issue is whether his return to Nigeria in light of his medical condition and in relation to family present would amount to a real risk of subjecting him to cruel, inhuman or degrading treatment. The Court of Appeal in AM (Zimbabwe) have clarified the extent of protection provided by Article 3 ECHR in medical cases following the judgement of the Grand Chamber of the European Court of Human Rights in Paposhvilli v Belgium. I do not accept the argument put by the respondent that the Court of Appeal have created separate law on this issue regarding when a removal should be stayed and when an appellant is entitled to remain as no such distinction can properly be made. I find that I am bound by the interpretation of Article 3 ECHR in this context given by the Court of Appeal in AM (Zimbabwe) until, and if, this is altered by any future decision of the Supreme Court.
43. At paragraph 38 of AM (Zimbabwe) Sales LJ says that the relevant test is whether: "the applicant faces a real risk of rapidly experiencing intense suffering (i.e. to the Article 3 standard) in the receiving state because of their illness and the non-availability there of treatment which is available to them in the removing state or faces a real risk of death within a short time in the receiving state for the same reason." Further this means: "the boundary of Article 3 protection has been shifted from being defined by imminence of death in the removing state (even with the treatment available there) to being defined by the imminence (i.e. likely "rapid" experience) of intense suffering or death in the receiving state, which may only occur because of the non-availability in that state of the treatment which had previously been available in the removing state." The Court of Appeal made plain that simply having a significantly lower life expectancy due to a lower quality of medical treatment does not suffice to meet this test.
44. The appellant suffers from sickle cell anaemia which is a condition he inherited and has had since birth and results in a state of chronic anaemia. His treating doctor, Dr Dimitris Tsitsikas, consultant haematologist at Homerton University Hospital stated in a letter dated 24th October 2016 that his conditions is a "very serious one and requires often specialist intervention and the lack of it may result in detrimental effects to his health and overall survival."

45. A letter of 1st May 2018 from this same doctor submitted by the appellant after the hearing for my consideration and not objected to by Mr Kotas for the respondent, and which I therefore admit as evidence, reiterates that the appellant suffers from severe sickle cell which results in him suffering from “frequent painful crises requiring hospitalisation for treatment with parenteral opiates”. He explains that “sickle cell disease is a very serious chronic illness associated with many acute and chronic complications that can be life threatening and is overall associated with a reduced life expectancy.” He also states that although the appellant has not required a blood transfusion in recent years: “his condition is such that an urgent blood transfusion usually of large volumes of blood maybe required in the context of common acute complications such as stroke, the acute chest syndrome or an aplastic crisis due to a common viral infection. In all of these situations immediate access to transfusion is crucial to patients’ survival”.
46. Another of the appellant’s treating doctors, Dr Amos, who is also a consultant haematologist, states in a letter of May 2012 that the appellant needs daily folic acid and prophylactic penicillin V. He states also that: “He will also experience from time to time episodes of acute bone pain, known as a sickle cell crisis, for which he will need appropriate painkilling medication....During the painful crisis patients are advised to take their oral analgesia on a regular basis until the pain subsides, they should rest, keep warm and maintain an adequate fluid intake,” Dr Tsiksikas, in his letter of March 2016, states that such a crisis may require hospitalisation for treatment with parenteral opiates due to severe bone pain. In this letter Dr Tsiksikas also states that triggers for crises will include: “infection, exposure to cold and damp, overexertion and physical and emotional stress.” Further: “sickle cell disease can also affect a multitude of other organs and systems such as the brain, eyes, heart, liver, skin, lungs, kidneys and bones.” As a result of these possible complications the appellant needs frequent monitoring of his condition.
47. The view taken by the various prison and detention centres as set out in the medical notes is that the appellant needs to go immediately to Accident and Emergency if he suffers a sickle cell crisis, this is stated explicitly at page B172 of the bundle by Dr Sayed a GP at the Heathrow Removal Centre and is reflective of the position in the rest of the prison medical notes. This position is also reiterated in the letter of Dr I Farmer of Queen Elizabeth Hospital at B377 of the notes who notes that the appellant told him on 13th July 2017 that he tends to have a painful crisis every 2 or 3 months, although he had not had one since November 2016, which was unusual, and that he had morphine when taken to hospital, and that historically he had multiple blood transfusions for chest crises.
48. The patient profile for the appellant from Homerton University Hospital for 2016 gives a history of his admissions to that hospital showing 22 admissions to their hospital and Whips Cross Hospital since the year 2000. It is clear that he is given morphine as his usual analgesic. It can be deduced that he is therefore in intense pain on these admissions, and indeed the last one in Homerton in April 2016 states “painful crisis” as the reason for his six-day admission.

49. If the more recent period of 2012 to 2017 is taken (and I deliberately start at this point as the appellant's gallbladder issues finished at this point making sickle cell his only medical issue) the patient profile evidence shows that the appellant has between 6 and 10 days in Homerton hospital in sickle cell crises a year. There were two admissions in 2012 and 2013, three admissions in each year in 2014 and 2015, and one in 2016. If the admissions for sickle cell crises from the other notes set out below are added these show that he had two further admissions to hospital in 2016: in June and October 2016. In 2017 there is evidence of his being hospitalised in August 2017 with two earlier crises being managed in prison.
50. In June 2016 the prison medical notes show that the appellant had an extremely painful sickle cell crisis in prison and was taken to Whittington Hospital by ambulance where he was given pain relief and kept for three days. He was also taken by ambulance to hospital due to pain in October 2016, and the details of this admission are set out in the Hillingdon Hospital which explain he was brought to hospital by ambulance for a sickle cell crisis from prison for a three-day period during which he was in acute pain and needed various antibiotics and intravenous pain relief via paracetamol and morphine.
51. In February 2017 the appellant informs the doctors he thinks he is going into crisis and gets some more painkiller medication but this not escalate into a hospitalisation. In May 2017 the appellant was in severe pain but this crisis was also managed in prison with pain relief. In August 2017 a doctor advised that he should not work in dust and heat, but otherwise was okay for work and gym. The appellant goes into a crisis in late August 2017 and is hospitalised again – the Frimley Park Hospital notes confirm this August 2017 crisis.
52. The prison/ detention centre medical notes show that the appellant sees medical staff very frequently, several times a month, for blood test checks and the prescription of vitamins, prophylactic antibiotics and painkillers even when he is not unwell. The prison/detention centre medical notes also reveal the appellant accepting he had alcohol and cannabis addiction problems in December 2017 and agreeing to a care plan to deal with these, and that he sought help for stress, insomnia and anxiety connected with fear of deportation due to his ill-health and separation from his children in December 2016 stating he had not felt this way before.
53. I find that a reading of the complete medical letters and notes lead me to the following conclusions. The appellant is a seriously unwell man with sickle cell disease. His condition needs constant monitoring and constant medication. Even in the context of this taking place about three times a year he will contract an infection and have a sickle cell crisis which will be extremely painful and require the strongest painkillers such as intravenous morphine and further antibiotics, and he is likely to be in hospital for about two to three days on each of these occasions. It is important he gets to hospital promptly when these crises happen, and they are to be seen a medical emergency and therefore life threatening and a cause of intense suffering. In addition to these crises which require hospitalisation he is likely to

have other crises, maybe around two, which are painful but can be managed without his being a hospital inpatient.

54. Frequent blood transfusions are not a feature of his necessary treatment in recent times, with the last one taking place in February 2012, although there is an indication in the notes that these might have been more frequent in the past prior to 2010 and the appellant's solicitors' schedule indicates there were probably at least two in 2008, one in 2011 and two in 2012.
55. I now move to examine the evidence on the treatment of sickle cell disease in Nigeria. It is an extremely common condition in Nigeria, in fact the Guardian newspaper article of 2017 entitled "As Nigeria loses 100,000 infants to sickle cell" suggests that one in four Nigerians has the sickle cell trait although not necessarily sickle cell disease. This is in keeping with the respondent's country of origin evidence. The Guardian newspaper article and the report from 2014 by Eme Innocent both indicate general short-comings in the Nigerian health system, the latter describing it as a shambles. The more focused study, "Autopsy findings and pattern of mortality in Nigerian sickle cell disease patients" from the Pan African Medical Journal May 2014 notes that the mean age of death in the sample was 21 years, with one of the commonest course of death being acute chest infections which leads to a pain crisis and causes cardiovascular collapse. It is clear from the medical notes that the appellant's crises are frequently anticipated by chest and other infections, see for instance the letter from DR Kakar of Hillingdon Hospital dated 21st October 2016 which notes that he had chest infection and was experiencing chest tightness and pain upon deep breaching when admitted with a sickle cell crisis. It is noted that the mean age of death in Nigeria is much lower than in Jamaica, France the UK or the USA where it is noted there is the use of prophylaxis and vaccination helps to reduce infections. This picture fits with the one given by Dr TP Omojasola of the Omolala Hospital, who also comments on the poor health care system struggling to provide for critically ill patients, and notes if blood transfusions are needed these are most provided by relatives, with endemic malaria in Nigeria increasing mortality in patients.
56. The review of scientific literature by Dr Amos, one of the appellant's treating doctors, in 2012 suggest that the median survival for sickle cell anaemia patients in Africa was likely to be less than five years. This literature review also leads to the conclusion that there is high prevalence of the condition; a lack of a formalised follow up health care system for sickle cell patients; complications with infections and particularly malaria which cause acute anaemia which would not respond to the prophylactic measures used outside of Africa, and a lack of availability and effectiveness of measures against malaria. Blood transfusions are reported as not being safe and pose a significant risk of the patient contracting hepatitis B or C or HIV. It is also Dr Amos's view that vital drugs to treat sickle cell are not available in Nigeria such as the daily penicillin V and regular vaccinations. It is notable that the appellant takes daily penicillin V. I see nothing in this review by Dr Amos which is not consistent with the picture in the respondent's country of origin report evidence of the same year.

57. Dr PI Abiola is a UK GP and also works for FEMTA MEDICAL which assists patients from abroad, and mostly Nigeria, to obtain private medical treatment in the UK. He was trained in medicine in Nigeria and practiced there until 1992 when he moved to the UK. He has worked in hospitals in the UK prior to completion of his GP training, and part of that work was at Kings College Hospital's sickle cell unit. He asserts that he has a good understanding of the treatment of sickle cell anaemia and also the current availability of treatments in Nigeria. He states that: "Mortality from sickle cell anaemia is usually from acute chest syndrome, heart failure, kidney failure and stroke. In Nigeria it is a rarity for a sickle cell patient to celebrate his 50th birthday because the facilities are simply not available to deal with the acute crisis they are prone to due to prevalence of malaria and the tropical heat they are exposed to. This is apart from the problems associated with blood transfusions which they frequently need. I have no doubt in mind that living in Nigeria with sickle cell anaemia has almost confined a person to a significantly reduced life expectancy and this would undoubtedly be applicable to PF."
58. The appellant has submitted a further report following the hearing from Dr Godwin Sule of the Karly Medical Clinic in Benin City, Edo State, Nigeria dated 3rd May 2018. He is a medical doctor working with sickle cell patients. The respondent has not objected to the consideration of this report and as a result I admit it as evidence before me. Dr Sule's opinion is that return of a sickle cell patient to Nigeria is as follows: "Generally speaking, poor medical facilities lead to severe complications and eventual death". His experience is: "80% of patients living with sickle cell in Nigeria die before the age of 35 due to poor health system and infrastructure. Hence, the mortality rate is over 65%". Specific problems Dr Sule identifies include lack of immediate adequate medical attention; strikes by medical staff; mosquito related disease; lack of authentic drugs; and difficulties stemming from a lack of family support.
59. Mr Kotas has rightly noted that there is a lack of comprehensive professional expert reports in this case, both with respect to the appellant's condition and prognosis and with respect to the availability treatment. It is correct that such evidence might well have made the decision-making more straight forward. Nevertheless, there has been an attempt by the appellant and his solicitors to provide a complete medical picture through submitting his entire prison/ detention centre medical notes and letters from treating doctors and through the provision of information about the treatment of sickle cell in Nigeria from a variety of different sources which provides a consistent picture. I conclude that this evidence, taken as a whole and combined with that from the respondent, is just sufficient to provide a credible picture of the situation for sickle cell sufferers in Nigeria.
60. I do not find that the evidence before me shows that the appellant has a real risk of death within a short period of time, although on the evidence before me I find there to be a real risk of death to the appellant within a five-year period. In coming to this finding I have relied firstly on the evidence of Dr Amos but have also found what Dr Sule and Dr Abiola say to have been supportive of this conclusion.

61. However, I do find that the appellant has shown a real risk of rapidly experiencing intense suffering to the Article 3 standard if returned to Nigeria because of his sickle cell disease and the paucity of treatment there as outlined above. Even in the UK the appellant is suffering two or three serious and extremely painful life-threatening crises a year requiring hospital admission, and perhaps two more a year which do not require admission to hospital, whilst being subjected to constant monitoring and taking his prophylactic antibiotics, which the expert medical evidence before me shows would probably not be available to him. Without these drugs he would be likely to suffer many more infections, and in addition he likely to suffer from malaria (a condition he has already suffered according to his medical notes) if returned to Nigeria, and would not be likely to find the medical facilities to both provide the heavy-duty morphine pain relief he needs or further antibiotics to treat the infections he has contracted. As a result I find I can properly conclude that the appellant would face an imminence of intense suffering in the receiving state which would occur due to the lack of treatment which is available in the UK but is not available in Nigeria.
62. Further I accept as credible the evidence of all the family members that there are no close family to whom the appellant could turn for nursing and support during any crisis and that none of them is able to return to Nigeria on a permanent basis and so the appellant would be at real risk of being in degrading conditions without support for washing, cooking, cleaning and shopping when in this extremely painful, dangerous and frequent state of ill-health. In this connection I accept the evidence of the witnesses that none of them is in a position to pay for any private health care or support to avoid the appellant being in this position, particularly as his partner is without the support of her mother, and thus in all likelihood no longer in a position to continue with full time work, and must provide for two children, and his adult daughter is now a single mother to a very young baby.
63. In the light of my conclusion on this issue it is not strictly necessary to look at Article 8 ECHR but given the onward appeals to the Supreme Court on Article 3 ECHR health issues I feel that it is prudent to give my reasoning on this issue too.
64. When looking at whether an exception to deportation based on Article 8 ECHR exists the Immigration Rules at paragraphs 398 and 399 and the parallel provisions in statute at s.117B of the 2002 Act must be applied. In the context of the appellant having been convicted to a sentence of imprisonment of four years or more the relevant factors that must be considered under s.117B of the 2002 Act are firstly the public interest in his being able to speak English and being financially independent must be acknowledged. Secondly little weight can be given to his private life ties to the UK and any relationship with a qualifying partner if they have been formed whilst his immigration status was precarious. Then thirdly, under s.117C of the 2002 Act, the appellant must be able to show that there are very compelling circumstances over and above one of the two exceptions to deportation which are either: that he has been lawfully resident most of his life; is socially and culturally integrated and there would be very significant obstacles to his integration in Nigeria; or that he has genuine and subsisting relationship with a qualifying

partner and/or a genuine and subsisting parental relationship with a qualifying child and the effect of his deportation on the partner or child would be unduly harsh.

65. In relation to the definition of unduly harsh it is decided in MM (Uganda) v SSHD [2016] EWCA Civ 617 that unduly does not simply mean excessive to be determined in relation to the child or children but that what is undue depends on all the circumstances which include the impact on the child or children and the appellant's criminal history and his immigration record. In relation to the meaning of very compelling circumstances in relation to children, the Court of Appeal have, as Mr Kotas has identified, made it plain that simple separation of British citizen children from a parent will not be enough and further evidence of rehabilitation which means that the appellant is at low risk of reoffending is not such a very compelling circumstance either, and that such an approach would result in a failure to acknowledge the public interest in deterring others and showing public revulsion at the offenders conduct. Mr Kotas also identifies authority that the appellant's own private life ties should, in accordance with s.117B(5) of the 2002 Act be given little weight due to his having rendered his indefinite leave to remain status precarious through his criminal conduct. For the appellant to succeed under Article 8 ECHR I am therefore looking for a very strong claim indeed, as per the guidance of the Court of Appeal in SS(Nigeria), this being all the more so in the context of the extremely poor criminal record of the appellant, which I set out below.
66. The appellant was convicted at Blackfriars Crown Court on 14th May 2010 of two counts of conspiracy to supply controlled drugs, namely class A heroin. He pleaded guilty to these offences on the basis he had a managerial role in respect of street dealing in this class A drug. As a result he was given a 5 year and 8 month prison sentence. This was the index offence which led to the signing of the deportation order by the respondent on 13th February 2013. He was imprisoned as a result of this sentence, I understand, between September 2010 and July 2013.
67. Prior to this the appellant had been given a four-year sentence of youth custody on 24th June 1997 for possession with intent to supply a Class A drug, and spent two years in custody between June 1997 and June 1999. Other offences committed by the appellant during the period 1997 to 2010 include theft, failing to surrender to custody at the appointed time, using threatening abusive and insulting words or behaviour with intent to cause fear and provoke violence, possession of ammunition without a certificate, and possession of a controlled drug class B cannabis. I understand that he spent 15 months in prison as a result of these convictions between November 2002 and February 2004.
68. After service of the deportation order the appellant received two further convictions. The first related to driving offences which led to his being given a 14-month sentence of imprisonment, for which he served three months between May and August 2016. The second was far more serious, on 21st March 2017 the appellant was convicted of conspiracy to supply a class A controlled drug for which he

received a four-year sentence of imprisonment. He was imprisoned on that date and remains in custody as a result serving sentence.

69. This latest sentence was given as a result of an offence committed in April 2016. I find that the appellant has attempted to minimise his role in evidence before me by saying what he did was to pass a telephone number from one person to another. The sentencing remarks of his Honour Judge Gordon CMG clarify that this was a conspiracy of five people involving 534g of pure heroin. Judge Gordon states the appellant was a type of manager for one of the major dealers to avoid direct contact between the major dealers, and that his role was at the upper end of significant. It was noted that he had two previous drug dealing convictions, but the first was when he was 16 years old and so the minimum term provisions did not apply to this, the second was however a major drug-dealing conviction. Judge Gordon accepted the appellant had another side to his personality as attested to by his sister and pastor, and that he was not well. In this context the sentence of 6 years that he would have passed after a trial was reduced to 4 years given the guilty plea.
70. As pointed out by Mr Kotas, even if the appellant is not likely to reoffend, as is the view of Dr Farhy psychologist (who appears not to know of the latest drug's conviction); the OASys report of May 2017 (which is clearly cognisant of this conviction) and his close family members who gave evidence who all regard him as a changed, scared and broken man (and clearly do have knowledge of his complete criminal offending) this is not a compelling factor which can make his deportation disproportionate. I make my decision on the basis that the evidence of the history of his criminal behaviour is such that given even his own partner could not explain why he had committed the crimes that it has to be accepted that there is a risk beyond a low one of drugs crime reoffending.
71. In the context of this appalling criminal history, including a lack of finding of any definite prospect of rehabilitation, I find that nothing except the medical issues outlined above in the discussion of Article 3 ECHR can raise, in combination with other factors, a different and sufficient case for the appellant's deportation to also be a disproportionate interference with his Article 8 ECHR rights.
72. I find that his deportation would be unlawful as it would amount to a disproportionate breach of his private life right to respect to moral and physical integrity as protected by Article 8 ECHR because of the probable medical consequences of his removal as set out above in the Article 3 ECHR discussion. I find that also relevant to his success on private life medical grounds in the Article 8 ECHR context is the appellant's long period of residence which has been lawful for a considerable part of that time and commenced with his entry to the UK as a 13 year old child: the fact that he has been in the UK for 27 years and was granted indefinite leave to remain in the year 2000 held this status until 2013 when deportation proceedings commenced; and finally that his English language ability must be seen as a neutral factor in this consideration.

73. The other aspect of the medical Article 8 ECHR claim which I find to be worthy of further consideration is whether the family life exception relating to his children, that his deportation raises very compelling circumstances over and above being unduly harsh to them, also makes out a way in which his claim can succeed because of his medical prognosis in Nigeria as set out above. To this end I examine the relevant evidence on this issue in the bundles. At this point it is relevant to consider the credibility of the witnesses before me. Mr Kotas has pointed out that the evidence given with respect to the frequency of sickle cell crises requiring hospitalisation would appear to be have been exaggerated by his partner MP, however I do not find that this was a deliberate attempt to mislead the Tribunal but reflective of her frustration and genuine fear of the appellant dying in Nigeria without the assistance of the medical services which is undoubtedly frequently needed in the UK, and that the stark memories of these medical emergencies have made them seem more frequent. I find the witness all to be generally credible and have given honest testimony, and thus be evidence that can be given weight in the context of the other evidence.
74. AF, who is 11 years old (who is the appellant's daughter from his relationship with his partner MP), has written her own hand written short letter to the Court in which she sets out that the deportation of the appellant would leave her "devastated" and "isolated" and that life without him due to his imprisonment is "hard enough" but if he is sent to Nigeria "will be even harder". CP comments in her statement that AF is worried about the appellant's deportation and missing him badly. MP set out in her statement that the appellant's deportation will "destroy AF, CF and AC", and the appellant refers in his statement to his deportation being "devastating" for his children and family as well as for him. KT attests to the time the appellant has devoted to their son, RF (who is now 3 years old), and to their mutual decision that he should play a part in RF's life. The evidence of all witnesses, which is supported by the school letters relating to AF is that the appellant being, when not imprisoned, regularly and actively involved with AF and RF's lives.
75. The appellant was present and living with AF from her birth in 2007 until she was three and a half years old. He was then in prison for almost three years until July 2013, when she was six and a half years old. He was then at liberty and living with AF until she was just over nine years old in May 2016 when he spent three months until August 2016 in prison for traffic offences, from which point he was then detained under Immigration Act powers until his release on bail in December 2016, when he spent one month with his family. He was then held on remand in relation to the charges which led to latest drug conviction from January 2017 until March 2017, at which point he started his sentence for his latest drugs conviction. The appellant has therefore lived with AF and been an active father sharing her home for just over half of her life. The appellant was at liberty from the time RF was born in February 2015 until he was just over one year old in May 2016. The only time he has had in the community with his son since this time was one month in December 2016 to January 2017. The prison visit documentation reveals a number of visits in prison by AF to her father for 2016, 2017 and 2018, and in 2017 and 2018 for RF, and I find that there is on-going meaningful contact between the appellant and these

two children despite the appellant's imprisonment by means of visits, telephone calls and other correspondence relying upon this evidence and the witness evidence.

76. There is insufficient information to fully understand the impact of the appellant's deportation on CF, who is the 17 year old son of MP and thus the appellant's stepson, who has some learning and behavioural difficulties relating to ADHD, to form a picture about the impact of deportation on him but it is accepted that the relationship he has with the appellant is a parental one.
77. Dr E Farhy is a chartered counselling psychologist who has provided a report which addresses the impact of the appellant's deportation on his minor children in the UK dated December 2016 based on interviews with the appellant, AF, AF's mother MP, the appellant's mother and his sister and with CP, as well as a review of the statements of the witnesses, deportation decision of the respondent, the appellant's probation documents and medical documents. I am satisfied that Dr Farhy is an appropriate expert to assess this issue, and that his report contains appropriate declarations including his duty to the court and to provide an objective unbiased opinion. He records the appellant being central to AF's life, and AP as seeing a marked decline in her mood and behaviour with the appellant being away in prison. His conclusion is that AF will find his deportation "highly upsetting and disruptive", and she is likely to become "upset and her development to be significantly disturbed". Of RF his opinion is that he is likely to feel that "the state had robbed him of his father". He also states that should the appellant die due to his ill-health the children would be likely to ask themselves if the appellant's behaviour justified not only deportation but a death sentence.
78. On the totality of the evidence before me I find that the probability that the deportation of the appellant will lead to his being in excruciating suffering on several occasions a year without adequate treatment and make his death predictable within a five- year period would be over and above unduly harsh to his children AF and RF, with whom he has a close and dedicated parental relationship capable of surviving separation in prison. I find, for the reasons I set out below, this can properly be described as a powerful and irresistible claim.
79. The impact would be particularly devastating for AF, whose mother (MP) would be predictably distraught by her own grief at the separation and medical decline of her partner in a far-off country (this being supported by her own statements and the letter from her GP that she is already having issues with sleeping, stress and low mood and been giving sleeping tablets) as well as having to suffer her own grief at this permanent separation and fears for the appellant's health. Dr Fahy talks of emotions of "rage and guilt" which are likely to "encumber them daily", and of likely behavioural and psychological issues with all of the minor children, as well as questions as to whether the appellant's criminal behaviour could really justify such consequences over and above the separation for which they would feel highly upset. It is in his favour that the appellant started these proceedings as a lawfully present person in terms of immigration status who had lived in the UK for a long

period of time since childhood. However, against him I acknowledge the severity of the appellant's criminal behaviour as set out above and the public interest in showing public revulsion at his criminality and in deterring other, and the situation where it must be acknowledged that there is a risk of recidivism connected with drugs crime. I acknowledge also that RF was born when the appellant's status in the UK was precarious as these proceedings were underway, although on the other hand AF was born when his status was secure with indefinite leave to remain. I make it plain that it is only the factor of his minor children, AF and RF, with an ongoing close parental relationship having to deal with the separation and probable extreme suffering and death from sickle cell disease within the period of their childhoods of their father, the appellant, directly linked to his deportation to Nigeria which I find to be over and above unduly harsh, and thus to meet the Article 8 ECHR exception at s.117C(5) of the 2002 Act.

Decision:

1. The making of the decision of the First-tier Tribunal involved the making of an error on a point of law.
2. The decision of the First-tier Tribunal was set aside with no findings preserved.
3. I re-make the decision by allowing the appeal on Article 3 and Article 8 ECHR grounds.

Signed: *Fiona Lindsley*
Upper Tribunal Judge Lindsley

Date: 16th May 2018

Annex A: Error of Law Decision

DECISION AND REASONS

Introduction

1. The appellant is a citizen of Nigeria born in 1977. He arrived in the UK in 1990 with his younger sister when he was 13 years old. He stayed with his older sister who already lived in the UK as student, and on 30th March 2000 he was granted indefinite leave to remain. On 3rd September 2010 he was convicted of conspiracy to supply a controlled drug class A and sentenced to five years and eight months imprisonment: this was the index offence which led the respondent to make a decision to make a deportation order on 13th February 2013 under s.32(5) of the UK Borders Act 2007. The appellant appealed against the decision to deport him and this appeal was allowed on human rights grounds by the First-tier Tribunal in a decision dated 10th July 2013. However, the decision was found to contain errors of law, and was set aside and the remaking remitted to the First-tier Tribunal in a decision of a Presidential Panel made on 12th February 2014. On 21st March 2017 the appellant was convicted of a further offence of conspiracy to supply a controlled class A drug and was given a further custodial sentence, this time of four years imprisonment. His appeal against the decision to deport was reheard and dismissed by First-tier Tribunal Judge Metzger in a determination promulgated on the 6th June 2017.
2. Permission to appeal against the decision of First-tier Tribunal Judge Metzger was granted by Upper Tribunal Judge Perkins on 1st November 2017 on all grounds on the basis that it was arguable that the First-tier judge Metzger had erred in law in failing to properly apply the decision of the European Court of Human Rights decision in Paposhvili v Belgium 13th December 2016 ECtHR given that it is accepted by the First-tier Tribunal that the appellant suffers from sickle cell anaemia and that he would not be able to access treatment for this in Nigeria.
3. The matter came before us to determine whether the First-tier Tribunal had erred in law.

Submissions – Error of Law

4. In the grounds of appeal and submissions it is contended that there were inadequate findings on the medical and expert evidence and a failure to consider these issues properly. There were expert reports from Dr Philip Abiola and Dr Omojasola who both say that the full medical treatment the appellant requires is not available in Nigeria. Further the medical evidence shows the appellant suffers from serious, life threatening medical problems. The First-tier Tribunal states that medical and psychological evidence was considered but it only gives limited weight to the

psychological evidence. Further the reports of Dr Abiola and Dr Omojasola, the country of origin expert evidence, were not considered at all. This was a material error in the context of the First-tier Tribunal seemingly accepting that there was a lack of relevant medical treatment for the appellant's serious sickle cell anaemia condition in Nigeria which would detrimentally affect the appellant's ability to survive given issues with blood transfusions and infections.

5. Secondly the First-tier Tribunal failed to consider the impact of the appellant's deportation and the serious possibility of his death on his British citizen family. In particular there was a failure to consider properly the best interests of the appellant's children when it was probable these children would never see the appellant again as he would be likely to die due to the lack of treatment for sickle cell anaemia in Nigeria. In the grounds it was said that the appellant's family life had become stronger because of the respondent's delays which were identified in the decision of the Presidential Panel granting permission to appeal against the decision of the First-tier Tribunal made in 2013, although this point was not pursued before us. There was evidence regarding the minor children from three adult witnesses (the appellant's oldest daughter, his partner and the mother of his youngest child), letters from them directly and a psychologist's report. There was insufficient consideration of the evidence and extent of the family life bonds between the appellant and his minor children, and in that context the harshness of his deportation given his likely early death from sickle cell related conditions in Nigeria, in turn brought about by a lack of available treatment there.
6. Further the legal approach to deportation taken by the First-tier Tribunal is flawed. Whilst it was right to give very significant weight to the public interest in deportation in the light of the appellant's very serious convictions it was possible that countervailing factors would make his deportation disproportionate. The Supreme Court in Hashem Ali [2016] UKSC 60 advocated a balance sheet approach, in which a First-tier Tribunal should set out the countervailing factors which are said to outweigh the public interest in the deportation of foreign offenders. This was approved of in the case of SSHID v Quarey [2017] EWCA Civ 47. There should have been consideration, in this exercise, of whether there were very compelling reasons over and above the factors in the exceptions to deportation at paragraph 399A and 399(a) of the Immigration Rules. It was important that in the balance was placed the fact that there was a likelihood of the appellant becoming seriously ill and passing away, and the likely impact on the minor children. There was no evidence that the First-tier Tribunal had gone through this process and set out argument in sufficient detail given the gravity of the issues at stake.
7. Mr Mahmood clarified that it was not argued that the appellant was entitled to succeed on Article 3 ECHR medical grounds, and this was not the case that was put before the First-tier Tribunal, on the basis of Paposhvili or in any other way. This was an Article 8 ECHR case relying on the impact of medical matters on the best interests of the children, making deportation disproportionate. Mr Mahmood noted however that a decision of the Court of Appeal on the Paposhvili issue should be delivered this afternoon.

8. In the rule 24 notice the respondent argues that there is no error of law for failure to consider Paposhvili as this case has no material application for the reasons set out in EA & Ors (Article 3 medical cases – Paposhvili not applicable) [2017] UKUT 00445. The report of Dr Abiola is considered at paragraph 16 of the decision, and there is no evidence that the appellant can meet the high threshold in Article 3 ECHR medical cases as set out in GS (India) [2015] EWCA Civ 40, where the appellants were going to die of end stage kidney disease due to lack of treatment in their country of origin. There is further very significant interest in the appellant's deportation given his very egregious criminal behaviour.
9. In further submissions Mr Clarke argued that even if there was a failure to conduct a proper proportionality exercise on the issue of whether the appellant's deportation was unlawful by virtue of whether it was unduly harsh to the children referring to paragraph 399(a) of the Immigration Rules this was not a material error as ultimately there was a proportionality assessment. He resisted the argument that the First-tier Tribunal had not properly set out the medical evidence regarding the appellant's condition and expert evidence with respect to sickle cell treatment in Nigeria. Mr Clarke argued that the First-tier Tribunal had balanced properly the significant weight to be given to the appellant's criminal behaviour against the appellant's accepted family life ties and his ill-health, and ultimately everything had been lawfully taken into account.
10. At the end of the hearing we told the parties that we found that the First-tier Tribunal had erred in law and that we would put our reasons in a decision in writing. Mr Mahmood stated that the appellant was happy to proceed immediately with remaking and the appellant's representatives had prepared a bundle of documents which updated the Tribunal about the appellant's medical condition and his family (which the Tribunal had received), however equally the appellant were happy for this remaking to take place on another day which would enable the appellant to place possible further up-dating evidence on Article 8 ECHR matters before the Upper Tribunal. Mr Clarke asked that the matter be adjourned for remaking as he had not received the bundle of updating evidence as he had had to replace another presenting officer at the last minute and needed time to prepare, and had not had access to the bundles. In these circumstances we agreed that it was fair to adjourn the remaking hearing to the first available future date.
11. Both parties and the Tribunal agreed that the remaking hearing would be limited to submissions only, and that reliance could be placed on the account of the witness evidence set out in the decision of Judge Metzger at paragraphs 3 to 15.

Conclusions – Error of Law

12. The Upper Tribunal found in EA & Ors that Paposhvili v Belgium 13th December 2016 ECtHR is not a test that it is open to the Tribunal to apply by reason of its being contrary to judicial precedent. In Paposhvili the Grand Chamber had held that the "other very exceptional cases" mentioned in N v UK included: " the removal of a seriously ill person in which substantial grounds have been shown for believing

that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy. The Court points out that these situations correspond to a high threshold for the application of Article 3 of the Convention in cases concerning the removal of aliens suffering from serious illness.” The Grand Chamber clearly moved the case law away from a protection only to those close to death, see paragraph 181 of that decision. However the Upper Tribunal in EA & Ors found itself bound by virtue of the law of precedent by the decision of the Court of Appeal in GS (India) which had not permitted such an extension of protection in medical Article 3 ECHR cases.

13. The error of law argued in this case is however one which relates to Article 8 ECHR, and not to Article 3 ECHR. EA & Ors cites GS (India) in pointing out that: “The only cases I can foresee where the absence of adequate medical treatment in the country to which a person is to be deported will be relevant to Article 8, is where it is an additional factor to be weighed in the balance, with other factors which by themselves engage Article 8.” This is the law relevant to the decision of the First-tier Tribunal in this case. It is also clear that the appellant puts forward many additional factors beyond his ill-health which engage Article 8 ECHR, not least the appellant’s family life with his three British citizen children, partner, his private life ties with extended family, and his private life ties with the UK formed during a period of residence since the age of 13 years. We therefore find that no error of law arises by virtue of the case of Paposhvili.
14. The First-tier Tribunal appears to misstate the law at paragraph 18 of the decision. It is not the case that there is no exercise under the Immigration Rules, as is implied at paragraph 18 of the decision simply because an appellant has a sentence of four years or more, paragraph 398 makes clear that in such circumstances the appellant would have to show very compelling circumstances over and above those in the exceptions at paragraphs 399 and 399A, which would therefore entail a consideration as to whether these exceptions could be met and then whether there was anything over and above which was very compelling, see Greenwood (No 2)(para 398 considered) [2015] UKUT 0062. At paragraph 20 of the decision of the First-tier Tribunal it is clarified that paragraph 398 is relevant but, we find, there is still no systematic assessment under the exceptions followed by a consideration of whether “there are very compelling circumstances over and above those described in paragraphs 399 and 399A”. These rules mirror the statutory provisions in s.117C of the Nationality, Immigration and Asylum Act 2002. The statutory regime represents Parliament’s directions as to the assessment of article 8 in cases involving the deportation of foreign criminals. The interpretation of the rules should be consistent with the statute.
15. The crux of this case, either under paragraph 399(a) and 398 of the Immigration Rules or under Exception 2 at s.117C(5) and s.117C(6) of the 2002 Act, is whether there are compelling circumstances over and above it being unduly harsh to the

appellant's two minor British citizen children, with whom it is accepted he has genuine and subsisting relationships, for the appellant to be deported and they remain in the UK. The question of what is unduly harsh is a proportionality exercise in which, as per MM (Uganda) & Anor v SSHD [2016] EWCA Civ 450: "What is due or undue depends on all the circumstances, not merely the impact on the child or partner in the given case. In the present context relevant circumstances certainly include the criminal's immigration and criminal history."

16. We find that whilst the criminal history is clearly set out at length, and rational findings made about his likely recidivism, that other matters have not been sufficiently reasoned and balanced. This is a case which unarguably involves difficult issues of the effect of deportation of a father suffering from sickle cell anaemia on children who are British citizens. The evidence before the First-tier Tribunal showed that the appellant would have a considerably reduced life expectancy in Nigeria. In the findings section the appellant's medical condition is reduced to a condition which has caused him "considerable pain and difficulty" since childhood. There is no summary of the appellant's severe sickle cell condition or of the expert evidence relating to lack of treatment, despite this being referred to in a summary of expert evidence at paragraph 16 as leading to a conclusion that there is "commonplace" mortality from sickle cell anaemia in Nigeria. There is also no analysis of the impact of the appellant's deportation on the children, which needed to be done individually for each child assessing the strength of the ties to the appellant and any individual vulnerabilities of the children. This would, in turn, have involved consideration of their evidence, the evidence of the adult appellants and the expert evidence of the psychologist. Conclusions need to be drawn as to whether the deportation of an appellant with a real risk that this would lead to his death as a result of inadequate medical services would meet the test in section 116C(6) namely that there were very compelling circumstances over and above the unduly harsh test in Exceptions 1 and 2 .
17. For these reasons we find that the First-tier Tribunal has erred in law: there was a failure to properly consider relevant evidence going to the proportionality assessment provided for by statute and under the Immigration Rules, and to provide a sufficiently reasoned decision that the balancing exercise fell against the appellant.

Decision:

1. The making of the decision of the First-tier Tribunal involved the making of an error on a point of law.
2. We set aside the decision of the First-tier Tribunal with no findings preserved.
3. We adjourn the remaking hearing.

Directions:

4. Any further evidence for the remaking hearing should be served on the other party and filed with the Upper Tribunal 14 days prior to the date of that hearing.

Pursuant to Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/269) we make an anonymity order. Unless the Upper Tribunal or a Court directs otherwise, no report of these proceedings or any form of publication thereof shall directly or indirectly identify the original appellant. This direction applies to, amongst others, all parties. Any failure to comply with this direction could give rise to contempt of court proceedings. We do so in order to avoid a likelihood of serious harm arising to the appellant's minor children.

Signed: *Fiona Lindsley*
Upper Tribunal Judge Lindsley

Date: 5th February 2018

Annex B

POST HEARING DIRECTIONS

1. Both parties should use their best endeavours to obtain the sentencing remarks of the Crown Court Judge in relation to the appellant's most recent conviction and file and serve these with the Upper Tribunal and the other party.
2. The appellant's legal team is to file and serve a chronology of the times the appellant spent in prison (the actual dates of his incarcerations and not the dates of the sentences given) and the dates of any blood transfusions in the last ten years by 4pm on 4th May 2018.
3. The appellant's legal team is to file and serve an explanation of what is meant by "The date of the decision causes a little confusion in this case" at paragraph 6 of the skeleton argument by 4pm on 4th May 2018 as this is not understood.
4. The respondent has until 4pm on 14th May 2018 to file and serve any submissions relating to Article 3 ECHR or the above issue at paragraph 6 of the skeleton argument.
5. The appellant has until 4pm on 16th May 2018 to file and serve any reply to any submissions the respondent may make on Article 3 ECHR.

Signed: *Fiona Lindsley*
Upper Tribunal Judge Lindsley

Date: 25th April 2018