Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: PA/02997/2015

THE IMMIGRATION ACTS

Heard at Field House	**Determination Promulgated**
On 30th October 2017	**On 28th September 2018**
& 30th July 2018	

Before

UPPER TRIBUNAL JUDGE COKER

Between

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Appellant

And

DO
(anonymity direction made)

Respondent

Representation:

For the Appellant: Mr P Duffy on 30th October 2017
Ms R Petterson on 30th July 2018
Senior Home Office Presenting Officers

For the Respondent: Ms B Smith, instructed by IR Immigration Law LLP

DETERMINATION AND REASONS

Pursuant to Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/269) I 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 appellant in this determination identified as DO. This direction applies to, amongst others, all parties. Any failure to comply with this direction could give rise to contempt of court proceedings

© CROWN COPYRIGHT 2018

1. For the reasons given in a decision promulgated on 7th November 2017, Upper Tribunal Judge King TD set aside the decision of First-tier Tribunal Judge Grimmett on the grounds that there was a lack of structured consideration of Article 3 in the light of established jurisprudence such as to amount to a material error of law. The findings on asylum and humanitarian protection made by Judge Grimmett were preserved. A transfer order was made, and the hearing listed before me on 1st March 2018. Unfortunately, that hearing had to be adjourned; I made the following order and directions:

    1. The First-tier Tribunal decision in so far as it relates to Article 3 and Article 8 findings having been set aside by UTJ King for reasons in a decision sent on 7th November 2017, the resumed hearing was set down for hearing before me today. Directions made by UTJ King had not been complied with and counsel for the appellant had been instructed that the hearing was an "error of law" hearing. UTJ King found no error of law by the First-tier Tribunal judge who had dismissed the appeal on international protection and humanitarian protection grounds. The resumed hearing is on Article3/8 grounds only.

    2. The most recent medical evidence available was that which was before the First-tier Tribunal and was a report prepared by Professor Hale in October 2016 after a visit to the appellant when she was detained in July 2016. No further medical evidence has been filed.

    3. As a consequence of the lack of compliance with directions and the lack of instructions given to counsel for the appellant, I had no alternative but to adjourn this hearing.

    4. I make the following directions:

        i. No oral evidence but updated witness statement of appellant to be filed and served, if so advised, by 4pm on 30th March 2018. The appellant is on notice that any evidence to be relied upon before the Upper Tribunal is to be served in an indexed and paginated bundle, even if previously before the First-tier Tribunal, no later than 4pm on 16th May 2018.

        ii. Any NHS medical evidence sought to be relied upon to be filed and served (separately to the bundle referred to above) by 4pm on 30th March 2018.

        iii. Appellant's solicitors to notify the UT and the respondent by 4pm on 30th March 2018 whether they intend to instruct any other medical professional and if so whom together with confirmation that instructions have been given.

        iv. If any medical evidence is relied upon other than NHS records, such evidence to be filed and served by 4pm on 30th April 2018.

    …

2. Although the directions regarding medical and other evidence were not complied with in terms of time, an up to date psychiatric report was filed on behalf of DO and Amnesty International provided a report taking that report into account. I record my gratitude to them for enabling the hearing on 30th July to proceed.

3. On conclusion of the hearing on 30th July 2018 and prior to my reaching a decision in this appeal, *SL (St Lucia)* [2018] EWCA Civ 1894 was handed down. I invited the parties to make written submissions on the relevance of that judgment which I duly received.

Background

4. DO entered the UK in 2000 with a valid spouse visa. She was granted indefinite leave to remain on 28th March 2002. On 12th February 2013, she was stopped at Gatwick airport, charged with drugs offences, pleaded guilty and was sentenced to 6 years and 6 months' imprisonment. A deportation order was signed. DO's human rights claim and claim for international protection were refused. Her appeal against the rejection of those claims was heard by First-tier Tribunal Judge Grimmett on 31st January 2017. He dismissed her international protection claim appeal but found that her medical condition was such that to remove her would be a breach of Article 3. Her Article 8 appeal was also allowed.

5. The Secretary of State sought and was granted permission to appeal the Article 3 and Article 8 decision. That appeal was allowed and the appeal was retained in the Upper Tribunal for findings to be made on Article 3 and Article 8.

6. Although the First-tier Tribunal judge had not been satisfied that DO's family had been killed as she claimed, the judge did accept that it was likely that DO had little or no contact with her family – whether in Togo or Ghana or Nigeria – and that she had had no contact since her detention. The focus of DO's challenge to the rejection of her human rights claim is her mental health.

7. DO was released from detention in the summer of 2016 and since October 2016 has been living with a friend in North London.

8. DO's claim is:

   (i) She is at real risk of harm because of her mental health and/or as a woman with her characteristics;

   (ii) There is a real risk that she will commit suicide if removed;

   (iii) Her living circumstances in Nigeria would fall below that which is acceptable; and/or

   (iv) There are compelling circumstances such that she should not be deported.

9. The appellant was released from detention in October 2016 since when she has been staying with her friend [A F] and his wife. She has been living there since her release from detention in October 2016, both of whom are British Citizens. In his statement prepared for the First-tier Tribunal hearing he said that he was happy to accommodate her and "help her financially if necessary". He is providing her with accommodation and, it seems, maintaining her day to day needs over and above the minimal support she is given by the state. There is no indication in the evidence before me that any financial assistance currently provided by Mr [F] would not continue to be given to DO after removal. There is no indication that he would not provide her with financial assistance, as stated in his witness statement.

Medical evidence

10. Professor Anthony Hale, fellow of the Royal College of Psychiatrists and Emeritus Professor of Psychiatry at the University of Kent, examined DO on 14th July 2016 whilst she was in Peterborough Prison and then again on 18th May 2018. He produced a report following both examinations. He had not had sight of DO's GP reports for either examination, but he had seen 370 pages of prison medical notes when he prepared his first report.

11. The medical diagnosis was not disputed by the respondent. DO has been diagnosed with severe major depressive episode with psychosis and accompanying suicidal ideation, generalised anxiety disorder with panic attacks, social phobia and post-traumatic stress disorder. In his most recent report, Professor Hale states that her mental state has not changed significantly since he examined her in 2016:

> "… She continues to be substantially psychiatrically handicapped by chronic severe major depressive disorder with psychotic and panic symptom, which is not responding to a combination of two antidepressants which I believe her GP has been prescribing for her since she left HMP Peterborough, and when I reassessed her, she had not been assessed by local services for cognitive behaviour therapy (CBT) or other evidence -based psychological therapy."

12. His report refers to a lightly reduced HDRS-17 score following her release from prison but concludes that allowing for a slightly less intrusive environment with slightly better resulting sleep, the severity of her depression is essentially unchanged. He refers to her reporting that she self-harms every few days, cutting, shouting and slapping herself. He does not record any suicide attempts since her release from detention.

13. In his 2018 report, Professor Hale concludes that if DO is forced to return to an environment which she regards as full of threat with the prospect of homelessness, social isolation and destitution, then her symptoms would likely worsen her fear of the risk of murder by Muslim extremists in Nigeria, a country to which she believes she is a foreigner, and where, she believes, she was raped, her father was murdered and four siblings died as well as having been in an abusive marriage. Professor Hale concludes that whether these fears are real or imagined, the consequences are such that she is at heightened risk of suicide.

14. Professor Hale considers the medication that DO is currently prescribed. He refers to two of the drugs in her current regime as "quite old drugs" and that given her high suicide risk

> "… it would be advisable to find an adequate substitute for amitriptyline as soon as possible. Such a process may take several months under expert supervision. Mirtazapine has some evidence of efficacy in PTSD…but there is more evidence for other classes of antidepressants which she has not been offered."

He goes on to say

> "The likely effect on her mental health should she be unable to access the treatment she requires following deportation to Nigeria are, in the short term, that withdrawing the antidepressant medication is likely to be a rapid relapse over

several weeks of the worst depressive symptoms, probably exacerbating suicidal ideas and putting her at increased risk of taking her own life.

… continuing on amitriptyline is not a safe long-term treatment because of potential cardiac toxicity in overdose, so substitution of a less toxic alternative before removal is desirable".

15. In addition to a change in this medication Professor Hale also recommends, as he did in 2016, trauma focussed CBT EMDR and trials of more potent and potentially combined or augmented antidepressant treatment. I have taken my decision on the basis of the medication and treatment she is presently receiving. Professor Hale lists a total of 14 drugs presently taken by DO.

16. DO has attempted suicide previously. Whilst in prison she was considered a person at risk of self-harm or suicide; her last suicide attempt was whilst in prison. Professor Hale records that DO informed him that she had been treated for an incident of self-harm (overdose) in Lewisham hospital in 2005 and that she thinks she was an inpatient for 1 or 2 months. No other details of this were before me. This appears to have been at the time she separated from her husband. The evidence before me discloses no report of any other attempt at suicide prior to imprisonment.

17. Professor Hale records that the appellant says she would like to be able to work

"… but [she] feels that her illness would prevent this at present even were she allowed to do so".

According to his report she would like to return to hairdressing

"… for which she has qualifications and she was able to pursue this to a limited extent whilst in prison".

18. He concludes that

102. … she continues to be substantially psychiatrically handicapped by chronic severe major depressive disorder with psychotic and panic symptoms, which is not responding to a combination of two antidepressants which I believe her GP has been prescribing for her since she left HMP Peterborough….

103. Her only psychological 'support' is some form of 'counselling' which she says she attends at her GP surgery. Counselling is not an effective intervention for severe major depression.

…

105. Given the nature of her psychotic symptoms, it is my clinical opinion that these are more likely to relate to PTSD than depression…..

106. Apart from the two longstanding antidepressants, she has received no evidence-based psychological treatments for PTSD (CBT and/or Eye Movement Desensitisation and Reprocessing, EMDR) since 2016. Her treatment needs are thus unmet for immediate treatment and it is premature to predict her treatment needs in the medium and long-term.

107. It is also premature to comment upon her treatment needs and access to services should she be deported to Nigeria, as such treatment needs would be determined by her response to and toleration of expert assessment and treatment in the short term in the UK.

> …
>
> 123. The likely effect on her mental health should she be unable to access the treatment she requires following deportation are, in the short term, that withdrawing the antidepressant medication is likely to be a rapid relapse, over several weeks, of her worst depressive symptoms, probably exacerbating suicidal ideas and putting her at increased risk of taking her own life.
>
> …
>
> 124. … It would be important to know whether [DO] could obtain medication in Nigeria and the extent to which that would be determined by whether she has money to pay. It would also be important for a suitably qualified expert to opine upon whether or not there is a danger that the medication on sale in Nigeria may be counterfeit copies and be ineffective or less potent.
>
> 125. Specifically it will be important to know whether she would be able to acquire antidepressants in Nigeria, for example, amitriptyline, whether this would be private prescriptions and, if so at what cost, and whether this would require private medical consultations (and at what cost) to obtain an initial prescription. However continuing on amitriptyline is not a safe long term treatment because potential cardiac toxicity in overdose, so substitution of a less toxic alternative before removal is desirable.
>
> …
>
> 132. At interview [DO] did not mention specifically fears of harm from the Nigerian authorities or others were she to return to Nigeria, but she says her depression is worsened by her fear of being deported….
>
> 133. I thus conclude that risk of her attempting suicide would be considerably heightened were a decision made to deport her to Nigeria, during the process of removal, during any period of pre-removal detention, and on arrival in Nigeria following removal.
>
> 134. … in my clinical opinion [DO] would be at high increased risk of suicide, both in the period leading up to deportation, and after arrival in Nigeria.

19. The Amnesty International report describes the availability of mental health care facilities. It draws attention to there being (as of 2015) 130 qualified psychiatrists in Nigeria, 7 specialist neuro-psychiatric hospitals and 12 teaching hospital psychiatric departments. Nigeria's population is in the region of 186 million; Lagos has an estimated population of over 20 million. Of the two anti-depressant drugs and the psychotropic drug that DO is prescribed, Amnesty reports that Mirtazapine and Amitriptyline are approved for use in Nigeria. Mirtazapine is available on prescription for N2500 for 28 tabs. Amnesty were unable to establish the price or availability of Amitriptyline. The third, psychotropic, drug, Aripiprazole, is not listed as approved for use in Nigeria. Amnesty comments

> "While principles of psychiatric good practice are widely promoted within the modern Nigerian psychiatric profession, the reality of under-resourced, overstretched staff, responding to great demand in difficult conditions leads to serious limitations on the level and availability of care provided. For a person suffering from serious mental ill-health, there may in principle be treatment available, particularly in Lagos which as a major city is relatively better served with psychiatric care that other parts of the country, but the range and suitability of treatments will be limited, a lack of outreach work means that the onus is

> entirely on the sufferer and their family to find treatment and competition for treatment places is fierce."

20. The two anti-depressants that [DO] is currently prescribed are available in Nigeria, albeit at a cost. Despite the report by Professor Hale in 2016, there has been no change in her anti-depressant and anti-psychotic medication and she has not been provided with trauma based CBT or EMDR. There has been no challenge to the nature of the care that she is being provided with in the UK. I have taken the view that although it may be that the best treatment the appellant can have is as described by Professor Hale, she is not getting that treatment here in the UK and the availability of her current treatment in Nigeria is based on her ability to fund and access it through the Nigerian health service, such as it is. Aripiprazole is not licensed for use in Nigeria and it therefore seems reasonable to assume that she would not be able to access it. Professor Hale's report concentrates on the effect of the withdrawing of the anti-depressant treatment and the potential rapid decline in her mental health and increase in suicide risk. Although he considers that long term reliance upon the two anti-depressants is not in her best interests, the fact is that the anti-depressant treatment she is currently receiving is available to her in Nigeria if she can pay for it.

21. The report does not indicate the possible or likely effect of stopping Aripiprazole or whether alternative drugs are available save to say that

    > "Without her antipsychotic her sleep would be further impaired and her hallucinations are likely to worsen causing long term damage and considerable anxiety."

    Professor Hale does not state that there are not viable alternatives to that antipsychotic drug; nor does the Amnesty International report. Professor Hale does not say that Aripiprazole is the only suitable one, or that a change could not take place easily and over a short period of time.

22. In terms of assessment of Article 3 and her health, the core matters I have taken into account are the treatment she is currently receiving, whether that treatment is available in Nigeria, the consequences of withdrawal of that treatment and the actual process of removal and its consequences. That there may be other, better treatments or medication for her is not a matter that I am required to reach a conclusion upon in order to determine this appeal. The issue is her return to Nigeria on her current prescribed medication. I have placed little weight on whether she would be able to access counselling in the light of Professor Hale's opinion that it is of little or no effectiveness. I have taken fully into account, and accept, that there is a shortage of psychiatric facilities, that competition is fierce and to the cost of such treatment, as evidenced by Amnesty International.

23. As referred to in *AM (Zimbabwe) & Anr* [2018] EWCA Civ 64, as "pithily" summarised in *GS (India)* [2015] EWCA Civ 40 at [66] the exceptional circumstances in which Article 3 will prevent removal to another country with lesser standards of care "is confined to deathbed cases". A person whose risk of suicide is judged to be imminent and real because of the state of his/her

mental illness might also be described as a "deathbed" case. On the evidence before me, DO does not reach that high threshold.

24. [175] of *Paposhvili v Belgium* (Application no. 41738/10) summarises the two scenarios in which Article 3 could prevent removal:

> The Court further observes that it has held that the suffering which flows from naturally occurring illness may be covered by Article 3, where it is, or risks being exacerbated by treatment, whether flowing from conditions of detention expulsion or other measures, for which the authorities can be held responsible (see *Pretty*…). However, it is not prevented from scrutinising an applicant's claim under Article 3 where the source of the risk of proscribed treatment in the receiving country stems from factors which cannot engage either directly or indirectly the responsibility of the public authorities of that country.

25. The court in *Paposhvili* continued:

> 183. The Court considers that the "other very exceptional cases" within the meaning of the judgment in N v United Kingdom ([43]) which may raise an issue under Article 3 should be understood to refer to situations involving 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….

26. The court in *Paposhvili* said

> (a) It is for the applicant to adduce evidence capable of demonstrating that there are substantial grounds for believing that, if removed, she would be exposed to a real risk of being subjected to treatment contrary to Article 3;
>
> (b) Where such evidence is adduced, it is for the authorities of the returning state in the context of domestic procedures, to dispel any doubts raised by it. The risk alleged must be subjected to close scrutiny in the course of which the authorities in the returning state must consider the foreseeable consequences of removal for the individual concerned in the receiving state in the light of the general situation and the individual's personal circumstances.
>
> (c) The impact of removal on the person concerned must be assessed by comparing her state of health prior to removal and how it would evolve after removal.

27. For DO it can be concluded that, the SSHD being aware of her fragile mental health, would place adequate safeguards in place on the making of the removal decision, her travel to the airport and her journey to Nigeria. Her health care has been managed whilst she has been in the UK; in prison she was specifically cared for as a suicide risk and she continues to receive treatment from her GP since her release from detention. The SSHD has seen the comprehensive report provided by Professor Hale and can be expected to take careful note of

his diagnosis and the potential risks identified. It is reasonable to conclude that adequate medical provision will be made by the SSHD during those periods of time.

28. The question arises of whether the receiving state, Nigeria, has effective mechanisms for reducing risk, such mechanisms being available and accessible to DO.

29. According to Professor Hale, DO spends time alone and becomes more anxious when with others. Amnesty International draws attention to the possible detention in police cells of those with mental health problems who have adverse contact with the police or because of adverse family intervention. The appellant's only previous adverse contact with the police arose from her drug offence. There is no assertion of a risk of reoffending and so no evidence based reason to suppose that this appellant, given her propensity to spend time alone would find herself in the future having adverse contact with the police. There is no family in Nigeria who would cause police intervention. Professor Hale's report does not indicate any behaviour by DO that would result in adverse attention from the police.

30. It is possible that in the future DO may be able to work again but I have disregarded that possibility in reaching my decision given that she last worked in the relative safety of confinement in prison and her lack of work since her release from detention, even on an unpaid or voluntary basis, despite the lack of evidence of any attempts made by her to get back into work. She is capable of undertaking some tasks because the evidence is that she helps with chores around the house. I have concluded, in reaching my decision, that DO would be unlikely to be able to work and would be returning to a country where, albeit not objectively well-founded, she has a genuine subjective fear of mistreatment. That fear is, according to Professor Hale, likely to be exacerbated on return to Nigeria.

31. There is no direct evidence available to me of her ability to find accommodation but, taking into account her expressed consideration of moving out from her friend's home but lack of action in that regard, her increased confusion and tenseness and anxiety when having to deal with people generally, her lack of motivation and energy and her lack of knowledge of Nigerian society, I am satisfied that she would be unable to find accommodation with any great ease and I have reached my decision acknowledging that she does not know anyone in Nigeria. Her friend has been providing assistance on a daily basis since her release from detention in October 2016. I do not know whether he has friends or relatives in Nigeria who might be able to assist her. I do not know whether he would be prepared to travel to Nigeria with her for a few weeks to assist her in getting established. I do not know whether accommodation can be found in advance of her removal. The Amnesty International report provides evidence that studio accommodation is available albeit at a cost of around the equivalent of £500 per year and two year's deposit has to be paid. But in the absence of adverse evidence of assistance and given her friend's expressed confirmation that he would provide financial assistance if necessary and, given her indication that she is considering moving out from her friend's despite it being difficult for her to find accommodation, I am satisfied that although she may experience

some short term difficulties, there is suitable accommodation available and she would find some.

32. I am satisfied that if DO were able to maintain her current medication of Mirtazapine and Amitriptyline, her risk of suicide would not be elevated to the slightly relaxed threshold outlined in *AM*. She would be alone in Nigeria, but she spends considerable periods of time alone here in the UK. Although she has been self- harming, she has not attempted suicide since her release from detention despite the continuing deportation proceedings.

33. Her friend, Mr [F], has said he will provide financial assistance if necessary. There is no evidence that he would not provide such assistance if DO were deported; he is already providing assistance sufficient to meet the appellant's accommodation and nutrition needs. Although there is competition for psychiatric services in Nigeria, the treatment she is getting here in the UK does not include frequent monitoring of her drugs; other than the counselling to which I have already referred, she is on repeat prescriptions and has been since she was in prison. Professor Hale's conclusions on elevated risk of suicide in Nigeria are predicated upon her not being able to access medication. He records that she has continuing suicidal ideation but has not acted upon this since her release from prison. Professor Hale records his opinion that her risk of attempting suicide would be considerably heightened were a decision to deport her made, during removal and on arrival in Nigeria ([133] of his report – see above). The fact is that a decision to deport her has been made, she has been undergoing an appeal process since 2016 and lost her appeal before the First-tier Tribunal and yet there has not been an apparent heightened risk. As stated above, it can be expected that the SSHD will ensure adequate safeguards on actual removal and there is no reason at all to doubt that the appellant's friend, Mr [F], will continue to provide the financial support that he has done previously or that he will do all that he can to assist the appellant in establishing herself in Nigeria.

34. In terms of her arrival in Nigeria, again the SSHD can be expected to provide adequate medical provision until she has at least passed through immigration control. Whether further assistance is provided for a period of time thereafter is a matter for the SSHD but on the evidence before me, given that she will continue to have access to her medication and given my findings in relation to accommodation, I am satisfied that she will not be at risk of Article 3 breach on arrival in Nigeria after passing through immigration control.

35. In terms of being in Nigeria, if her current medication were to continue, as it is in the UK with such low-level monitoring, the evidence does not point to a heightened risk of attempted suicide. She is recorded as being self-aware.

36. Taking all these matters into account I find that removal of DO from the UK to Nigeria pursuant to the deportation order would not result in a breach of Article 3.

Article 8

37. DO entered the UK in 2000 and was granted indefinite leave to remain on 28th March 2002. She remained lawfully in the UK. On 12 February 2013, on returning to the UK from Grenada, she was found in possession of class A drugs. She was charged with, and pleaded guilty to, being knowingly concerned in the fraudulent evasion of the prohibition or restriction on importation of class A drugs. On 11th April 2013 she was sentenced to 6 years and 6 months imprisonment. It was her first and only criminal offence. It was submitted on her behalf that the sentencing judge acknowledged that she was a carrier but that despite "clear evidence that she had suffered from mental health problems prior to committing the offence", that did not appear to have been considered by the sentencing judge. The sentencing judge states that she has no doubt at all but that DO did the crime for the "purpose of financial gain; in short greed". The judge says she has taken account of mitigating factors. DO was legally represented. There is no evidence that her counsel did not place all appropriate mitigation before the judge and that such mitigation was not taken into account by the judge. There was no evidence before me that DO sought permission to appeal her sentence. The fact is that DO was sentenced for a first, very serious, offence to which she pleaded guilty and she was sentenced to a period of imprisonment in excess of 6 years. There is no basis upon which to attempt to minimise her offence or to attempt to re-mitigate the sentence.

38. Her psychiatric problems seem to have worsened since her conviction. Nevertheless, for the same reasons as I have set out above in relation to Article 3 I am satisfied that she would be able to re-establish herself in Nigeria, albeit with some difficulty.

39. Although it was submitted that DO has formed significant social cultural and family ties in the UK, that is not supported by the evidence. She does have one good friend but she does not go out and spends much of her time alone. This is not indicative of significant social or cultural ties. She does not have family in the UK.

40. Although submitted that DO would have significant difficulties in integrating into Nigeria, there was little evidence to support that contention other than referred to above. It has to be remembered that to successfully plead Article 8 in a deportation case where the sentence is over 4 years, there have to be very compelling circumstances over and above those set out in the exceptions. The evidence before me was that DO is not socially and culturally integrated into the UK. She stays with her friend and his wife, does not go out, spends a considerable amount of time lying down and expresses a desire to learn to speak better English. The evidence before me does not point to there being very significant obstacles to her social and cultural integration in Nigeria. The Amnesty International report refers to the discrimination faced by individuals with mental health problems and the difficulties faced by lone women and that the combination of both of these factors will place DO at risk. Whilst there may be a generality of such issues in Nigeria, in this case DO will have the financial support of her friend; there was a paucity of evidence that DO will have particular difficulties.

41. Although DO clearly has serious and debilitating physical and mental health problems, these do not, given she would be able to retain some financial assistance from her friend, amount to very compelling circumstances. Despite the fact that DO is assessed as at low risk of re-offending, the public interest requires her deportation.

42. Her removal would not result in a breach of Article 8.

Conclusions:

The making of the decision of the First-tier Tribunal did involve the making of an error on a point of law.

I set aside the decision

I re-make the decision in the appeal by dismissing it

Anonymity

The First-tier Tribunal made an order pursuant to rule 45(4)(i) of the Asylum and Immigration Tribunal (Procedure) Rules 2005.

I continue that order (pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008).

Date 25th September 2018

Upper Tribunal Judge Coker