Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: HU/18271/2016

THE IMMIGRATION ACTS

Heard at Field House
On 7 December 2018

Decision & Reasons Promulgated
On 14 February 2019

Before

DR H H STOREY
JUDGE OF THE UPPER TRIBUNAL

Between

MR S B
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr F Habtemariam, Counsel instructed by Immigration Advice Service
For the Respondent: Ms A Everett, Home Office Presenting Officer

DECISION AND DIRECTIONS

1. In a decision sent on 17 July 2018 I set aside the decision of Judge Oliver of the First-tier Tribunal dismissing the appeal of the appellant, who has claimed at different times to be a national of Liberia or of Sierra Leone, against the decision made by the respondent on 18 July 2016 to refuse him leave to remain on human rights grounds. The appellant, who came to the UK in October 2003, has a history of mental illness and at the date of the error law hearing and this hearing was in

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24-hour supported accommodation. Medical reports from Dr Ahrens and others stated that he currently suffers from both positive and negative symptoms of paranoid schizophrenia.

2. The reasons I set aside the decision of the First-tier Tribunal judge were (i) that the judge was wrong in law to rely on the reported Upper Tribunal decision **EA & Others** [2017] UKUT 00045 since that case had been disapproved by the Court of Appeal in **AM (Zimbabwe)** [2018] EWCA Civ 64; and (ii) that having seemingly concluded that the appellant would not receive adequate medical treatment in either Liberia or Sierra Leone (because in neither was clozapine available), the judge did not treat that as a relevant consideration in applying the Article 3 test.

3. In my decision, I stated that I did not consider it would an appropriate case to remit to the FtT since it has already been before the FtT/predecessor body twice. Whilst there were issues in factual dispute they were largely confined to the state of background country evidence as regards facilities for mental health treatment in Liberia and Sierra Leone. I directed that:

> "(1) The appellant's representatives obtain and produce within the next six weeks an up-to-date psychiatric report which addresses, inter alia, whether the appellant's mental and/or physical health would be significantly affected if clozapine (as opposed to other antipsychotic drugs) were not available;
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> (2) Both parties use best endeavours to obtain up-to-date country information relating to mental health facilities in Liberia and Sierra Leone and the range of locally available drugs for treatment or management of paranoid schizophrenia."

4. In response to my directions the appellant's representatives submitted two reports, one from country expert Huguette Ticky Monekosso dated 3 December 2018 and one from Dr Jennifer Perry, a Consultant Psychiatrist at the Lambeth Low Intensity Treatment Team, South London and Maudsley NHS dated 21 August 2018.

5. The report from Ms Huguette Monekosso stated that there is no evidence that clozapine is available in either Liberia or Sierra Leone and in neither of these countries are there facilities to monitor the side effects and safety of psychiatric drugs. Even if clozapine could be purchased over the internet, the appellant would not be able to afford it in either country and would not have any sophisticated equipment and highly qualified psychiatric professionals to monitor it for him. Even in the "parallel market" he would not be safe as this drug can be counterfeit or out of date medication which could put him in danger. In addition, the appellant would face adverse societal attitudes towards mental illness. If he is undocumented and does not know any local community or groups or have any attachment in either country, it would be very difficult for him to be accepted. She concludes at para 120 of her report that hat "In my view [the appellant] would face serious risks if he was sent back to Sierra Leone or Liberia as an undocumented mentally ill person"; and at para 1122 she adds that he "will face not only the medical problem that clozapine does not exist in Liberia or Sierra Leone, but he

will be regarded as stateless as he is undocumented. In addition to societal attitudes about his mental health problems". At para 135 she states:

> "I would also like to comment that if [the appellant] 's current friends or his supporters in the UK send money to Sierra Leone or Liberia to buy [him] any treatment for example… either the treatment will not be available or the people taking care of him will prefer to buy counterfeit medicine in the local market or simply take him to see a traditional doctor instead of trying to see the existing rare psychiatrists and neurologists in the country. Because [he] is a mentally ill person he would be accused of witchcraft so that people around home [sic] he may live".

6. The report from Dr Perry chronicled the appellant treatment history as set out in his medical notes. This confirmed that since he was started on clozapine in 2012 there had been a marked improvement in his condition. Dr Perry states that:

> "When I reviewed the appellant in August he described ringing in his ears on a daily basis rather than voices. He described feeling paranoid that people are watching him and talking about him. He seems to be afflicted by the negative symptoms of schizophrenia. He had a blunted affect, poverty of speech, lack of motivation and cognitive deficits associated with chronic psychosis. When asked about suicidal thoughts he said he could not remember but he said that he does not have any current suicidal thoughts or plans. He is currently treated with clozapine 425mg once a day, aripiprazole 10mg once a day, lamotrigine 200 mg once a day.
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> It is my opinion that [the appellant] has a severe psychotic illness which is treatment resistant. From reviewing his notes, it seems that clozapine is the medicine which has helped most in relation to his symptoms. The NICE Psychosis and schizophrenia in adults Quality standard (QS80, published February 2015) states: Clozapine is the only drug with established efficacy in reducing symptoms and the risk of relapse for adults with treatment-resistant schizophrenia. It is licensed only for use in service users whose schizophrenia has not responded to, or, who are intolerant of, conventional antipsychotic drugs.
>
> Healthcare professionals have noted that clozapine has helped [the appellant] to be more communicative, and has significantly reduced his auditory hallucinations in combination with other medications. He continued to suffer with predominantly negative symptoms. It is my opinion that if he were not on clozapine and instead on another antipsychotic that his mental health would deteriorate.
>
> Finally, I would very strongly support [the appellant's] claim to remain in the UK. He is a man with severe and enduring mental illness which is treatment resistant. The support he gets from his mental health and supported accommodation is important in ensuring this gentleman stays well. "

7. In her submissions Ms Everett accepted that there was no evidence to suggest that clozapine would be available to the appellant through medical treatment sources in either Liberia or Sierra Leone. However, it was clear from the expert report that there were other drugs available to treat the appellant's mental health condition and that there were medical facilities in both countries for the treatment of persons with his type of mental condition, albeit very few and of inferior quality. Dr Perry's view was that without clozapine the appellant's situation would deteriorate but she did not go on to say that this would lead to an irreversible decline. The evidence did not establish the level of suffering required to cross the high threshold set by the European Court of Human Rights for health cases. Dr Perry had not suggested that the appellant would not take the drugs he could obtain or access. His condition was treatment-resistant and he had been living with it for a long time.

8. It could not be assumed from the evidence, added Ms Everett, that the appellant had no family or friends in either country or that friends here could not assist him in gaining access to clozapine via the internet. He had clearly had friends and or family in the UK who had helped him financially in the past.

9. Mr Habtermarian highlighted the seriousness of the appellant's present condition. He was living in 24 hours support accommodation. Doctors in the UK had tried to treat his condition with other drugs but that had proved unsuccessful; only clozapine appeared to enable him to manage his condition and even then, he required a great deal of support from health professionals. Applying the latest guidance from the Court of Appeal in **MM (Malawi) and MK (Malawi)** [2018] EWCA Civ 2482, the appellant came within the second category identified in **Paposhvili v Belgium** [2017] Imm AR 867 at para 183. It was clear from the Court of Appeal decision in **MM (Malawi)** that the burden of proof shifted to the respondent too show the appellant would not be at risk. The appellant had been in the UK since 2003 and he has no links any more with either Liberia or Sierra Leone.

My decision

10. It is pertinent to set out key paragraphs of the latest Court of Appeal decision on Article 3 health cases, in **MM (Malawi)**. At paras 7-10. Hickinbottom LJ stated:

> "7. In respect of article 3 medical cases, the decision of the House of Lords in N was therefore clear, principled and binding on all domestic courts and tribunals; and endorsed by the ECtHR.
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> 8. However, the ECtHR has recently revisited the issue. In Paposhvili v Belgium [2017] Imm AR 867 at [183], the court said:
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> > "The court considers that the 'other very exceptional cases' within the meaning of the judgment in [N] ... 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 …".

That guidance is clearly different from – and, to an extent, more relaxed than – that in N.

9. The consequences of Paposhvili for medical cases in which there is reliance on article 3 were considered by this court in AM (Zimbabwe) v Secretary of State for the Home Department [2018] EWCA Civ 64; [2018] 1 WLR 2933, in which Sales LJ gave the lead judgment with which Patten LJ and I agreed. For the purposes of the appeals before us, it is unnecessary to set out Sales LJ's comprehensive analysis in detail. The following, relevant to the appeals before us, can be drawn from the case.

i) Despite the guidance given in Paposhvili, as a result of the principle of *stare decisis*, i.e. the usual rules of precedent in this jurisdiction, the test in N remains binding on this court, and indeed all tribunals and courts in this jurisdiction, subject only to the Supreme Court using its power to overrule it (see [30]).

ii) Paposhvili at [183] relaxes the test for violation of article 3 in the case of removal of a foreign national with a medical condition (see [37]). As Sales LJ put it at [38]:

"… [T]he 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."

iii) However, whilst acknowledging that relaxation of the test, Sales LJ considered "it does so only to a very modest extent". The article 3 threshold in medical cases remains high. He said:

"41. It is true that if one read the phrase 'would face a real risk … of being exposed … to a significant reduction in life expectancy' in [183] out of context, it might be taken to indicate a very wide extension of the protection of article 3 in medical cases, since in very many such cases where a foreign national is receiving treatment at a higher level of effectiveness in the removing state than would be available in the receiving state (e.g. in the case of those suffering from AIDS) they would be able to say they would face a real risk of a significant reduction of life expectancy if they were removed. But this is not a tenable interpretation of [183] of Paposhvili, read in its proper context. [N] was itself a case where removal resulted in a very significant reduction in life expectancy (as was also noted in Paposhvili at [178]), in which no violation of article 3 was found, and the Grand Chamber in Paposhvili plainly regarded that case as rightly

decided. [N] was itself a Grand Chamber judgment, decided by 14 votes to 3. It is impossible to infer that by the formula used in [183] of Paposhvili the ECtHR intended to reverse the effect of [N]. Moreover, the Grand Chamber's formulation in [183] requires there to be a 'serious' and 'rapid' decline in health resulting in intense suffering to the article 3 standard where death is not expected, and it makes no sense to say in the context of analysis under article 3 that a serious and rapid decline in health is *not* a requirement where death rather than intense suffering is the harm expected. In my view, the only tenable interpretation of [183], read in context, is the one given above.

42. In that regard, it is also significant that even on the extreme and exceptional facts of the Paposhvili case, where the applicant faced a likelihood of death within 6 months if removed to Georgia, the Grand Chamber did not feel able to say that it was clear that a violation of article 3 would have occurred for that reason had he been removed…".

iv) In respect of the correct approach and burden of proof, Sales LJ said this (at [16]):

"It is common ground that where a foreign national seeks to rely upon article 3 as an answer to an attempt by a state to remove him to another country, the overall legal burden is on him to show that article 3 would be infringed in his case by showing that that there are substantial grounds for believing that he would face a real risk of being subject to torture or to inhuman or degrading treatment in that other country: see, e.g., [Soering] at [91], which is reflected in the formulations in Paposhvili at [173] and [183]. … In Paposhvili, at [186]-[187] …, the Grand Chamber of the ECtHR has given guidance how he may achieve that, by raising a *prima facie* case of infringement of article 3 which then casts an evidential burden onto the defending state which is seeking to expel him."

10. In the two cases before us, the Applicants and Appellant – rightly – concede that (i) the test for article 3 medical cases set out in N as explained in AM (Zimbabwe) is binding on this court, and (ii) none of them is able to satisfy that test. However, they submit that, unlike the individual cases in AM (Zimbabwe), they each satisfy the test in Paposhvili; and this court, whilst bound to refuse their appeals, should give permission to appeal to the Supreme Court to enable that court to reconsider N in the light of Paposhvili."

11. Based on the thrust of the submissions I heard, it is common ground between the parties that the appellant's appeal rests entirely or predominantly on whether or not he can succeed on Article 3 grounds.

12. The issue of the appellant's nationality remains somewhat unresolved. However, at the hearing before Judge Oliver, the Presenting Officer stated that, absent

verified evidence to the contrary, the appellant would be returned to Liberia if the appeal failed and Mr Habtermarian took the view that it made little difference which of the two countries he was returned to. The judge proceeded, therefore, to assess the Article 3 risk that the appellant might face by reference to both countries. No issue was taken with this approach by Mr Habtermariam and Ms Everett accepted that to consider risk in relation to both countries, ensured fairness to the appellant. Whilst the issue of the appellant's nationality remains unresolved, it is reasonably likely that he is either a national of Liberia or Sierra Leone or a national of both. There is no evidential basis to indicate that he is stateless. Nor is there any evidential basis for concluding that if the decision to remove the appellant is confirmed, that he would be returned to either country undocumented.

13. I am not persuaded that the appellant can succeed on Article 3 grounds.

14. As regards the report from Ms Huguette Monekosso, it is common ground that it accurately describes the state of mental health facilities in both Liberia and Sierra Leone. I attach considerable weight to it in that connection. However, her report also contains a significant amount of speculation about the likely circumstances of the appellant on return, positing for example that he would be returned undocumented or that he is in fact a stateless person.

15. Mr Habtermariam does not seek to argue that if the appellant has access to clozapine in both countries he would still be unable to meet the high threshold established by the case law. The medical evidence relating to the appellant's treatment in the UK does not show that there has been any significant problem with the appellant taking the drugs that have been prescribed to him.

16. The report from Ms Monekosso is consistent with the respondent's own assessment that there are mental health facilities in both countries, albeit they are very limited and overstretched. On the basis of the evidence taken as a whole, I do not consider that it can be said that the appellant would be unable to access such facilities.

17. As regards the issue of the availability of clozapine, there is not now any dispute about the lack of clozapine as a drug used for treatment by mental health facilities in both Liberia and Sierra Leone.

18. Does this mean that the appellant's case must be assessed on the basis that he will not have clozapine available as a drug upon removal to either of these countries?

19. I am just persuaded that that is the position. It cannot be excluded that the appellant would be able to receive financial help from friends in the UK designed to have this drug sent to him in one or other of these countries. I regard it as purely speculation on the part of Ms Monekosso to suggest that the result of any such arrangement would be that the appellant would end up with counterfeit drugs; she does not evidence her assertion to that effect. The question I have to ask however, is whether it is reasonably likely that such arrangements would be available to this appellant. Dr Perry's report notes that at some point in his period of stay in the UK "family member supported [him] to move to London." She also

refers to a medical note relating to February 2007 which records an incident previous to 2007 when a "family friend" reported that he was sexually inappropriate to her daughter. A letter from a health project worker, Jamie Grant, dated June 2015 refers to him working with the appellant to contact family friends. At the same time, the respondent's position in her refusal decision is that the appellant "was known to be entirely without family members" (see para 44). Further, Ms Everett put her submission regarding the potential for financial support from family and friends in the UK at the level of possibility, rather than real possibility. Taking the evidence as a whole, I consider it would be unsafe to decide the case on the basis that the appellant would have financial support from family or friends in the UK to help obtain clozapine over the internet if he is removed.

20. It remains to consider whether the lack of availability of clozapine suffices to establish that the appellant meets the high threshold set in Article 3 medical cases.

21. Applying the principles set out by the Court of Appeal in recent case law, I am not persuaded that its absence would result in a serious, rapid and irreversible decline in the appellant's state of health resulting in intense suffering. His mental illness, that of paranoid schizophrenia, is long-standing and even though it has only improved through treatment involving clozapine, his medical history does not indicate that when he was treated by other antipsychotic drugs this caused a serious, rapid and irreversible decline in his state of health. The medical evidence given most recently by Dr Perry states that if he faces treatment without clozapine his condition would deteriorate, but does not assert that the level and extent of the deterioration would be such as to be serious, rapid and irreversible.

22. As regards the risk of suicide, Dr Perry's report states, echoing an earlier report from Dr Cristina Posada dated May 2015, that from his notes she could not see any history of suicide attempts or violence.

23. The report from Ms Monekosso states that in both Liberia and Sierra Leone the appellant would face stigmatisation and ostracism. However, although the appellant has stated that both his parents are dead and although he has not been living in either Liberia or Sierra Leone since 2003, he has not sought to claim that he has no other extended family members in these countries who might reasonably be expected to offer him some support and assistance. Against that background, I consider it speculative to assert (as does Ms Monekosso) that he would not be able to exist without falling into a serious and rapid spiral of self-neglect and poor living conditions.

24. I have sympathy with the appellant's plight. He suffers from a serious mental health condition. However, the law I have to apply has set a high threshold for success in such cases and the evidence in the appellant's case falls short of crossing that threshold.

25. For completeness, I would point out that Mr Habtemariam's submission regarding the burden of proof does not square with what was stated by Sales LJ in **AM (Zimbabwe)**. It is clear from that decision that in an Article 3 health case the

appellant has the legal burden overall of proving that there are substantial grounds for believing he would face a real risk of treatment contrary to Article 3. Once the appellant has established a prima facie case, the evidential burden shifts to the respondent. Taking account of the appellant's initial claim and the respondent's response (which relied, inter alia, on background country information) I fail to see that the position before me now is one where the respondent bears any particular evidential burden; the principal focus in this appeal has not been establishment of the facts but evaluation of the legal principles to be applied to them. Even if the respondent does bear the evidential burden, I am satisfied that on my assessment above she has discharged that burden.

26. Although I was not addressed (except glancingly) regarding Article 8, I state for the sake of completeness that I consider the appellant's to be a case where what was said by Laws LJ in **GS (India) v Secretary of State for the Home Department** [2015] EWCA Civ 40 has particular resonance. The threshold to succeed in a health case under Article 8 is also high and neither the appellant's length of stay in the UK nor the circumstances of his medical history or his current treatment regime and supported 24-hour accommodation suffice to establish private life circumstances that outweigh the public interest in the maintenance of immigration control so as to require the appellant's removal.

27. To summarise:

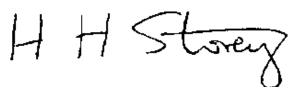
The decision of the First tier Tribunal judge has already been set aside for material error of law.

The decision I re-make is to dismiss the appellant's appeal.

Direction regarding anonymity

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

Signed Date: 10 December 2018



Dr H H Storey
Judge of the Upper Tribunal