Upper Tribunal
(Immigration and Asylum Chamber) HU/09751/2019 (V)

THE IMMIGRATION ACTS

Heard remotely by *Skype for Business*	Decision & Reasons Promulgated
on 17 February 2021	on 03 March 2021

Before
UPPER TRIBUNAL JUDGE MACLEMAN

Between
OBASOHAN

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

For the Appellant: Mr P Harvey, Advocate, instructed by Latta & Co, Solicitors
For the Respondent: Mrs H Aboni, Senior Home Office Presenting Officer

DETERMINATION AND REASONS

Procedure to date.

1. FtT Judge Green dismissed this appeal by a decision promulgated on 14 August 2019.

2. The decision of Judge Green was set aside by a decision promulgated on 17 March 2020, which should be read with this determination.

3. The main point in setting aside was that the judge was misled by an expert misquoting her instructions on whether she was to opine on "significant obstacles" rather than on "very significant obstacles" to the appellant's (re)integration in Nigeria.

4. For the remaking of the decision, parties were directed to provide outlines of their submissions, referenced to the evidence and to the law. (Various extensions of time were subsequently granted, and further extensions are hereby granted, to enable all materials to be considered.)

5. In a submission dated 14 October 2020, the SSHD sought disclosure from the appellant about her medication.

6. On 18 January 2021, the appellant's solicitors provided a country expert report by a social anthropologist, Prof. Jacqueline Knorr, dated 7 January 2021, "to be read in conjunction" with the medical report of Dr Erica Peters, consultant physician in infectious diseases, dated 26 August 2020.

7. On 16 February 2021, the appellant provided a consolidated bundle, comprising case law and the two above reports.

8. On 17 February 2021, the respondent provided her Country Policy and Information Note (CPIN), "Nigeria, Medical and Healthcare Issues", version 3.0, January 2020.

9. I am obliged to both representatives for their clear and well-referenced submissions, after which I reserved my decision.

AM (Zimbabwe) [2020] 2 WLR

10. The legal landscape on medical cases has changed since the FtT's decision. As this case has developed, the appellant's submissions on remaking focused on that matter. Mr Harvey contended that this is a prime example of a case which would not have succeeded previously but did now. For the new legal framework, he referred to an unreported decision of UTJ Gleeson, not as an authority, but as a convenient summary. Mrs Aboni agreed that it accurately sets out the applicable law, so I adopt that summary:

    On 29 April 2020, the Supreme Court gave the following guidance on the approach now to be adopted following the decision of the European Court of Human Rights in *Paposhvili.* The most important passage is at [22]-[23] in the opinion of Lord Wilson JSC, (with whom Lady Hale JSC, Lady Black JSC, Lady Arden JSC and Lord Kitchin JSC agreed):

"22. Following a careful analysis of the decision in the D case and of its own decision in the *N* case, the Grand Chamber in the *Paposhvili* case expressed the view in para 182 that the approach hitherto adopted should be "clarified". The Convention is a living instrument and when, however appropriately, the ECtHR charts its growth, it may generate confusion for it to claim to be providing only clarification. The court proceeded as follows:

> "183. The Court considers that the 'other very exceptional cases' within the meaning of the judgment in *N v The United Kingdom* (para 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. 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."

… So the Grand Chamber was thereby explaining that, in cases of resistance to return by reference to ill-health, article 3 might extend to a situation other than that exemplified by the *D* case, cited in para 14 above, in which there was an imminent risk of death in the returning state.

Its new focus on the existence and accessibility of appropriate treatment in the receiving state led the Grand Chamber in the *Paposhvili* case to make significant pronouncements about the procedural requirements of article 3 in that regard. It held

> (a) in para 186 that it was for applicants to adduce before the returning state evidence "capable of demonstrating that there are substantial grounds for believing" that, if removed, they would be exposed to a real risk of subjection to treatment contrary to article 3;
>
> (b) in para 187 that, where such evidence was adduced in support of an application under article 3, it was for the returning state to "dispel any doubts raised by it"; to subject the alleged risk to close scrutiny; and to address reports of reputable organisations about treatment in the receiving state;
>
> (c) in para 189 that the returning state had to "verify on a case-by-case basis" whether the care generally available in the receiving state was in practice sufficient to prevent the applicant's exposure to treatment contrary to article 3;
>
> (d) in para 190 that the returning state also had to consider the accessibility of the treatment to the particular applicant, including by reference to its cost if any, to the existence of a family network and to its geographical location; and
>
> (e) in para 191 that if, following examination of the relevant information, serious doubts continued to surround the impact of removal, the returning

> state had to obtain an individual assurance from the receiving state that appropriate treatment would be available and accessible to the applicant.
>
> These procedural obligations on returning states, at first sight very onerous, will require study in paras 32 and 33 below."

At [32], Lord Wilson confirmed the Supreme Court's understanding that *Paposhvili* was more than 'mere clarification of what the [European Court of Human Rights] had previously said'. In effect, there would now be a shifting burden of proof. It was for the appellant to adduce evidence 'capable of demonstrating that there are substantial grounds for believing' that there is a risk on return of an Article 3 ECHR breach. That is not an undemanding threshold: the requirement is for the appellant to raise a *prima facie* case of potential infringement, which if not challenged or countered, would establish that infringement.

At [33], the guidance in Lord Wilson's judgment concludes:

> "33. In the event that the applicant presents evidence to the standard addressed above, the returning state can seek to challenge or counter it in the manner helpfully outlined in the judgment in the *Paposhvili* case at paras 187 to 191 and summarised at para 23(b) to (e) above. The premise behind the guidance, surely reasonable, is that, while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state. What will most surprise the first-time reader of the Grand Chamber's judgment is the reference in para 187 to the suggested obligation on the returning state to dispel "any" doubts raised by the applicant's evidence. But, when the reader reaches para 191 and notes the reference, in precisely the same context, to "serious doubts", he will realise that "any" doubts in para 187 means any serious doubts. For proof, or in this case disproof, beyond all doubt is a concept rightly unknown to the Convention."

At [34], Lord Wilson recorded that neither party had actively invited the Court to refuse to follow *Paposhvili*:

> "[34]. …Our refusal to follow a decision of the ECtHR, particularly of its Grand Chamber, is no longer regarded as, in effect, always inappropriate. But it remains, for well-rehearsed reasons, inappropriate save in highly unusual circumstances such as were considered in *R (Hallam) and R (Nealon) v Secretary of State for Justice (JUSTICE intervening)* [2019] UKSC 2, [2020] AC 279. In any event, however, there is no question of our refusing to follow the decision in the *Paposhvili* case. For it was 15 years ago, in the *N* case cited at para 2 above, that the House of Lords expressed concern that the restriction of article 3 to early death only when in prospect in the returning state appeared illogical: see para 17

above. In the light of the decision in the *Paposhvili* case, it is from the decision of the House of Lords in the *N* case that we should today depart."

The report of Dr Peters.

11. Dr Peters was asked to opine on these questions:

1. What is Ms Obasohan's current treatment and medication for HIV?

2. How often does this treatment and medication need to be reviewed or adjusted?

3. How well controlled is Ms Obasohan's HIV at present?

4. If Ms Obasohan's current treatment and medication were not available to her in Nigeria (either because there was an absence of appropriate treatment or a lack of access to it), what effect would this have on her health? Would her health decline? If so, how serious would that decline be, how quickly would it happen and would that decline be reversible? What suffering would any such decline cause?

5. If Ms Obasohan's current treatment were not available to her in Nigeria, would this lead to a reduction in her life expectancy? If so, how significant (i.e. how substantial) would this reduction in life expectancy be?

12. The report explains that the appellant was first diagnosed in 2005 in Brighton and had complications including secondary kidney failure, with a resistant HIV virus requiring modification of her therapy. After 2011 she was fairly stable in terms of her medication, with an "undetectable viral load" when she came under the care of the Dr Peters in 2013.

... her medication was reviewed in 2016 and switched to ... dolutegravir, darunavir and ritonavir. She has remained on this drug combination since then with well controlled HIV ...

Due to [her] previous history all antiretrovirals are not suitable ... It would be important to choose antiretrovirals that showed no further resistance and further have no toxicity in light of her renal failure.

I cannot comment on whether the medication she is currently on, namely rezolsta and dolutegravir, is available in Nigeria... If she was not on antiviral therapy this would eventually be fatal.

... a timescale ... is very difficult ... but I would anticipate a reasonably rapid progression to death over ... a couple of years.

... if she remains on this medication we would expect her to have a normal life expectancy and she only requires to attend for check-ups twice a year.

The report of Professor Knorr.

13. Under the heading “Facts and figures concerning HIV / AIDS” the main points in the report are:

> 1.8 million people in Nigeria were living with HIV in 2019.
>
> Only 33% of those with HIV were receiving treatment in 2017.
>
> Only a quarter of those receiving treatment had achieved viral suppression.
>
> ARV drugs are officially provided free, but policy is far from reality.
>
> Even common ARV drugs are liable to “stock-outs”. “Based on my information from written sources and personal acquaintances … dolutegravir (DTG) … is among the drugs heavily affected by irregularities in supply and stock-outs. I am not aware of rezolsta being available in Nigeria”.
>
> DTG is particularly expensive … not affordable to most … however … generic and cheaper versions (3.50 euros per month) were introduced in 2017 …
>
> Although drugs are free, patients often have to pay for other services such as tests and travel to clinics, which many infected people cannot afford.
>
> Distributors of drugs often demand payment, which is transferred in various ways to patients.

The CPIN.

14. The passages to which I was referred are these (all based on reputable sources; I have not included the citations):

> 1.1.5 Access to and availability of quality health care inadequate; most Nigerians unable to afford health care.
>
> 4.1.1 Low numbers of doctors and other health workers (especially in rural areas and the north).
>
> 5.1.1-3 Distribution of and access to drugs problematic; access to treatment for chronic diseases, such as malaria and AIDS, estimated at 40%.
>
> 5.1.6 Chaotic distribution, and shortages, of drugs.
>
> 6.7 Free ARV drugs policy introduced in 2006.
>
> 6.7.2 Human resources and infrastructure “sufficient to meet the HIV care country’s needs”.
>
> 6.7.4 Free HIV treatment available “in all public facilities as well as designated private facilities”.
>
> 6.7.6 Treatment centres arranged to minimize geographical barriers; more available in urban than in rural areas.

Annex A, Available drugs: list includes dolutegravir, darunavir and ritonavir, but not rezolsta.

Availability of treatment?

15. In absence of treatment, the appellant's case would succeed.

16. Mrs Aboni said that the consultant's report was unclear on current treatment, while Mr Harvey said that was plainly rezolsta and dolutegravir. On this point, Mrs Aboni is right.

17. The report says firstly that the drug combination is dolutegravir, darunavir and ritonavir. It then contradicts itself by saying that the combination is rezolsta and dolutegravir.

18. The report does not show that rezolsta is an indispensable ingredient in the appellant's treatment.

19. Even if rezolsta is not available in Nigeria, many other drugs are, including the first mentioned combination.

20. Those other drugs may include equivalents to rezolsta.

21. Although neither representative explored the point in submissions, I note that the respondent's decision said that "rezolsta and dolutegravir, or their equivalents, are available in Nigeria".

22. The evidence does not support a finding that an appropriate combination of drugs for the appellant is not available in Nigeria.

Access to treatment?

23. With an appropriate drug, or combination of drugs, the appellant has a normal life expectancy. Is there a real risk that she will be unable to access those drugs?

24. There are difficulties of access to treatment in Nigeria, but the appellant does not fall at the level of least advantage. She is well versed in her medical needs, and can plan in advance. She can return with the benefit of an initial support package from the respondent. There is no reason to suppose that she would choose to live far from medical facilities, rather than close to a clinic. Drugs should be available publicly, without charge, but even if she has to pay, they are likely to be cheap.

25. The source of the information at section 6 of the CPIN on HIV / AIDS is a "MEDCOI country factsheet". A major plank of Mr Harvey's argument was that this section of the note selected only one source, and that it did not

sit well with the generalities in the rest of the note or with the report of Professor Knorr.

26. The preface of the CPIN explains how its information has been selected. MEDCOI is an Asylum and Immigration Integrated Fund financed project to obtain country of origin medical information. It allows 11 EU and 3 other states to use information from qualified doctors and other experts working in countries of origin. Although Mr Harvey said that section 6 is based on a single source, that source is a professional and reputable one, drawing on primary informants. Section 6 does not paint such a bleak picture as earlier sections, or as the report of Professor Knorr, but the note moves from the general to the specific, and its choice of source is made accordingly.

27. On all the evidence, there is no real risk of the appellant being unable to access treatment, such as to expose her to a serious, rapid and irreversible decline in her state of health, to intense suffering, or to a significant reduction in her life expectancy. Her case under article 3 does not succeed.

Article 8.

28. Mr Harvey submitted that even if it fell short under article 3, the appellant's case could succeed under article 8. He referred to *PF (Nigeria) v SSHD* [2019] EWCA Civ 1139. He said that lack of treatment, since *AM*, carries a greater weight than was accorded by earlier authorities. He accepted that there had to be additional factors, over and above lack of treatment. He relied upon 5 positive matters from the appellant's life in the UK, and 3 adverse matters about return to Nigeria:

    (i) Her long time spent here, 18 years.

    (ii) Her long absence from Nigeria, 22 years.

    (iii) Her private life, accumulated over that period.

    (iv) Her ability to speak English, which was a positive and not simply a neutral feature.

    (v) Her church activities, and the unwillingness of her church to support her, if she were to return to Nigeria.

    (vi) The stigma attached to HIV, giving rise to difficulties over employment, and a likelihood of having nowhere to stay.

(vii) Lack of extended family support, with a particular impact on her as a single woman.

(viii) A real risk, with her profile, of economic and social destitution.

29. The long time the appellant has spent here needs to be put in the context of her immigration history. She came in 2002 as a visitor, and overstayed. She had discretionary leave from 2012 to 2015 but has failed to establish various claims in proceedings since then. It is not the worst of examples which come before tribunals, but it is not greatly to her credit.

30. Ability to speak English, if it is to the appellant's credit at all, is of little weight.

31. There is nothing to stop the appellant pursuing church activities in Nigeria.

32. Mr Harvey said that the FtT erred in holding that the appellant's church in the UK was likely to extend its support to her, because that was contrary to the evidence. I am not persuaded that there was anything wrong with the finding that a church willing to help the appellant financially here was likely to continue to do so there, even if the church said otherwise. In any event, I find that whether the appellant is helped in that way does not weigh significantly in the article 8 balance.

33. The appellant failed to establish in various proceedings to date her claims that she would be returning as a lone, lesbian, vulnerable female with no family or other support. There is no reason to substitute any more favourable findings on those matters.

34. It is possible that the appellant might obtain some support, if she needed it, at least initially, from her adult children, or from extended family in Nigeria; but the article 8 balance does not depend on a definite finding that such support would be provided.

35. A risk of destitution might support an article 3 and not merely an article 8 claim. However, there is no reason to find that the appellant would be in any greater difficulty in Nigeria than the average single woman of her age. She has no disabilities in the job market. While she would have to readapt, nothing of significance stands in the way of her integration into her country of origin. That conclusion is fortified by the availability of an initial support package from the respondent. She falls well short of the private life requirements in paragraph 276ADE of the immigration rules. There is no absence of medical treatment, and no set of additional factors, to disclose that the appellant has a right to remain in the UK under article 8.

36. The decision of the First-tier Tribunal has been set aside. The decision substituted is that the appeal, as originally brought to the FtT, is dismissed.

37. No anonymity direction has been requested or made.

Hugh Macleman

19 February 2021

UT Judge Macleman

NOTIFICATION OF APPEAL RIGHTS

1. A person seeking permission to appeal against this decision must make a written application to the Upper Tribunal. Any such application must be **received** by the Upper Tribunal within the **appropriate period** after this decision was **sent** to the person making the application. The appropriate period varies, as follows, according to the location of the individual and the way in which the Upper Tribunal's decision was sent:

2. Where the person who appealed to the First-tier Tribunal is **in the United Kingdom** at the time that the application for permission to appeal is made, and is not in detention under the Immigration Acts, the appropriate period is **12 working days (10 working days, if the notice of decision is sent electronically).**

3. Where the person making the application is in detention under the Immigration Acts**, the appropriate period is 7 working days (5 working days, if the notice of decision is sent electronically)**.

4. Where the person who appealed to the First-tier Tribunal is **outside the United Kingdom** at the time that the application for permission to appeal is made, the appropriate period is **38 days (10 working days, if the notice of decision is sent electronically).**

5. A "working day" means any day except a Saturday or a Sunday, Christmas Day, Good Friday or a bank holiday.

6. The date when the decision is "sent' is that appearing on the covering letter or covering email.