Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: DA/01209/2013

THE IMMIGRATION ACTS

Heard at Field House, London	**Decision & Reasons Promulgated**
On Wednesday 9 and Friday 11 February 2022	**On Tuesday 22 March 2022**

Before

MRS JUSTICE FOSTER
UPPER TRIBUNAL JUDGE PLIMMER
UPPER TRIBUNAL JUDGE SMITH

Between

AM (ZIMBABWE)
[Anonymity direction made]

Appellant

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Mr Z Malik QC and Mr D Balroop, Counsel instructed by JCWI
For the Respondent: Mr R Dunlop QC and Mr W Hansen, Counsel instructed by GLD

Anonymity
Rule 14: The Tribunal Procedure (Upper Tribunal) Rules 2008
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 his family. This direction applies, amongst others, to

both parties. Failure to comply with this direction could lead to contempt of court proceedings.

DECISION AND REASONS

INTRODUCTION

1. This is an appeal on human rights grounds against the Respondent's decision dated as long ago as 6 June 2013, making a deportation order against the Appellant. After a lengthy procedural history we now re-make the decision on the sole outstanding issue in dispute: will the Appellant's deportation to Zimbabwe breach Article 3 of the ECHR?

2. This is a decision to which we have all contributed. Where reference is made below to documents before us, those are contained in the consolidated bundle ([CB/xx]), the Appellant's supplementary bundle ([ABS/xx]), the Respondent's supplementary bundle ([RBS/xx]), and the Respondent's second supplementary bundle ([RBS2/xx]).

3. An anonymity order has been made throughout these proceedings and we maintain that order. This decision raises wide-ranging issues concerning the Appellant's health and makes references to his minor children. For those reasons we consider it appropriate to continue that order. We make clear that the direction is not made to protect the disclosure of the Appellant's criminal offending.

PROCEDURAL HISTORY

4. The Appellant initially appealed the Respondent's decision on the basis that deportation to his home country of Zimbabwe would be disproportionate due to the interference with the right to respect for his family and private life in the UK and therefore pursuant to Article 8 ECHR. He relied primarily on his medical condition. He was diagnosed as suffering from HIV in either 2003 or 2005.

5. In a decision promulgated on 3 November 2014, First-tier Tribunal Judge Cameron dismissed the appeal on human rights grounds noting expressly that there was no evidence "sufficient to reach the high threshold to engage article 3" ([CB/282] at §102).

6. Following the grant of permission to appeal to this Tribunal, Upper Tribunal Judges Eshun and Allen maintained Judge Cameron's decision in a decision promulgated on 19 May 2015. The Tribunal found there to be no error of law in Judge Cameron's decision, the Tribunal again asserting that "[i]t was clear that Article 3 was not relied upon" ([CB/309] at §17).

7. It was not until the appeal reached the Court of Appeal that the focus of the Appellant's case shifted to Article 3 ECHR. The Appellant no longer challenged the dismissal of his appeal on Article 8 grounds. As a result, the decision of Judge Cameron as upheld by this Tribunal stands, having been finally determined. In the Court of Appeal the Appellant asserted that his deportation to Zimbabwe would lead to a real risk of torture,

inhuman and degrading treatment contrary to Article 3 ECHR. This remains the sole issue in dispute.

8. At the time of the Court of Appeal proceedings, domestic law was as set out in the case of N v Secretary of State for the Home Department [2005] UKHL 31 ("N") but since the decision of the House of Lords in that case the issue of Article 3 in 'health cases' has been considered by the ECHR in the judgment of the Grand Chamber of the ECtHR in Paposhvili v Belgium [2016] ECHR 1113 ("Paposhvili"). The Appellant in this case accepted that the Court of Appeal was bound by the judgment in N but reserved his position in relation to an appeal to the Supreme Court. His appeal was duly dismissed by the Court of Appeal on 30 January 2018 ([2018] EWCA Civ 64).

9. However, on 29 April 2020, in this Appellant's appeal to the Supreme Court (AM (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17 - "AM (Zimbabwe)"), it reversed the Court of Appeal, giving guidance on the approach to Paposhvili in domestic law. The Appellant's appeal was allowed and remitted the appeal for re-hearing before this Tribunal on Article 3 grounds. So it is that the appeal comes before us.

10. As the Supreme Court said, "[t]his appeal requires the court to consider one of the most controversial questions which the law of human rights can generate …", dealing with the tension between the public interest in the deportation of a foreign criminal and the individual's claimed right to remain because of his health condition. As the Court added "considerations of public policy on the one hand and of what is said to be private existential need on the other clash like warriors; and upon the courts lies a heavy burden in determining which should, under the law, prevail".

BACKGROUND FACTS

11. We do not need to deal in detail with the background history or the Appellant's offending. Briefly, the Appellant came to the UK in December 2000 as a teenager and was subsequently granted leave to remain as the dependent of his mother who was working here. He was subsequently granted indefinite leave to remain in 2004.

12. The Appellant has a long criminal history dating back to 2004 when he was still a minor. In 2009, when in his early twenties, he was convicted of drugs and firearms offences and sentenced to nine years in prison. Even when released on licence, the Appellant committed a further offence and was recalled to prison. After his sentence had ended and he was at liberty, he once again committed offences involving drugs. His latest conviction was in October 2021 for offences committed in 2019.

13. The Appellant was diagnosed as HIV positive (in either 2003 or 2005). His condition is now controlled by medication in the form of anti-retroviral drugs ("ARV"), the detail of which we deal with below. His condition is also monitored, and he is tested in order to ensure that his anti-viral load

remains low and his CD4 count (which measures CD4 cells in blood) remains high. We address the detail of the Appellant's ARV medication and the monitoring and testing he has available to him in the UK below.

14. The Appellant is married to [N] with whom he has one child, now a teenager. The Appellant and [N] began their relationship in around 2004 and their child was born in 2006. They married in 2012. The Appellant also has three other children (born in 2014, 2018 and 2019 respectively) with two other women. The Appellant has described his family life as complicated but says that his wife gets on well with the other two mothers and their children. His father and brother also live in the UK.

15. We do not need to deal any further with the Appellant's family or private life. He does not rely on Article 8, indeed, he could not, since his appeal on this basis has been finally determined. We deal with the evidence in so far as it is relevant to his Article 3 case.

LEGAL FRAMEWORK

16. We were taken to only two authorities by the parties: AM (Zimbabwe) which makes extensive reference to Paposhvili, and; the recent judgment of the Grand Chamber of the ECtHR in Savran v Denmark dated 7 December 2021 (application no. 57467/15) ("Savran"), which of course post-dates Paposhvili.

17. There is very little if any disagreement between the parties as to the legal principles which now apply in this appeal, and we can therefore summarise them relatively shortly.

(1) Article 3 ECHR is an absolute and fundamental right. It prohibits in absolute terms torture and inhuman or degrading treatment or punishment and its guarantees apply irrespective of the reprehensible nature of the conduct of the person in question. In a removals case, where there is a real risk that an individual will face treatment contrary to Article 3 in the receiving state, removal cannot take place. In such circumstances, the responsibility of the removing state is engaged by the removal itself.

(2) The threshold which must be reached in order for treatment to breach Article 3 is high. Article 3 requires a "minimum level of severity". As explained by the Supreme Court in AM (Zimbabwe) at [31], what is required to be shown is either a "serious, rapid and irreversible decline" in the applicant's health "resulting in intense suffering" or "a significant reduction in life expectancy". In this context, "significant" means "substantial" in line with the alternative of the serious implications on health leading to the intense suffering.

(3) As set out at [32] of AM (Zimbabwe) and reiterated at [130] of Savran, the burden is on an applicant to adduce evidence demonstrating "substantial grounds" for believing that it is a "very exceptional case" because of a "real risk" of subjection to treatment contrary to Article 3.

(4) Two important points emerge from this: first, it is for the applicant to adduce the requisite evidence - this is an application of the basic principle that "if you allege a breach of your rights, it is for you to demonstrate it"; second, the test represents a threshold which in the words of Lord Wilson in this case, is a "not undemanding" one. Whether the minimum level of severity is met is relative and depends on all the circumstances of the case.

(5) The first step is for the applicant to raise a "prima facie" case. As the Supreme Court said at [32] of AM (Zimbabwe), "[t]his means a case which, if not challenged or countered, would establish the infringement". The Supreme Court referred with approval to the guidance provided by this Tribunal at [112] in AXB v Secretary of State for the Home Department [2019] UKUT 00397 (IAC).

(6) In the event that an applicant provides evidence which establishes a "prima facie" case or as the ECtHR refers to it, if the applicant meets "the threshold test", it is then for the returning state to seek to counter that case ([32 and 33] of AM (Zimbabwe) and [135] of Savran). As the Supreme Court in AM Zimbabwe concluded, the reference in Paposhvili to a requirement to dispel "any" doubts must be read as meaning "any serious doubts". That is further explained by the Grand Chamber in Savran as being an obligation not only to "dispel any doubts" raised by an applicant's evidence but also "to subject the alleged risk to close scrutiny by considering the foreseeable consequences of removal for the individual concerned in the receiving State, in the light of the general situation there and the individual's personal circumstances" ([130(b)]). The returning state must verify whether the care generally available in the receiving state is sufficient and appropriate, and the extent to which the applicant will actually have access to the treatment in question ([130(c) and (d)].

(7) Where, after the relevant information has been examined, serious doubts persist regarding the impact of removal on the applicant, the returning state must obtain individual and sufficient assurances from the receiving state as a precondition for removal, that appropriate treatment will be available and accessible – see [130(e)] of Savran and the sequence of the Paposhvili steps summarised within [23] of AM Zimbabwe.

18. It appeared to be suggested by Mr Malik in the course of his oral closing submissions that, once an appellant has raised a sufficient doubt by his evidence, the only way in which a returning state can proceed with removal is by seeking assurances. If that is what he meant to say, we consider that he is wrong as the foregoing makes clear. There is an intermediary step where the Respondent may provide evidence which would dispel "any serious doubts" raised by the Appellant's evidence. If that is done, the obligation to seek assurances will not arise,- see [130(b) – (d)] of Savran, as set out above.

19. As the Supreme Court observed at [33] of AM (Zimbabwe), a returning state may well be "better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state". However, as will become clear when we look at the evidence in this particular case, both parties are likely to contribute to the establishing of that position. Mr Malik suggested during his submissions that it was not for us to prefer the evidence of one expert over another. That may be right. However, as we understood him to accept, it is for us to decide what will be the position for the Appellant on return to Zimbabwe, i.e. whether the evidence, properly considered, constitutes substantial grounds for believing that the Appellant would face a real risk of a relevant outcome, which may include reaching a conclusion about any differing opinions.

20. As both parties submitted and we accept, although we have to establish the position which the Appellant will face on return to Zimbabwe in terms of his medical needs, it is "not a question of ascertaining whether the care in the receiving State would be equivalent or inferior to that provided in the healthcare system in the returning State" ([131] of Savran).

21. Ultimately the Article 3 question for us to determine is governed by the test set out at [183] of Paposhvili (cited at [22] and explained further at [31-33] of AM (Zimbabwe)). This test was helpfully dissected into its component parts by Mr Dunlop in his skeleton argument as follows:

> "The …other very exceptional cases…which may raise an issue under article 3 should be understood to refer to situations involving the removal of [1] a seriously ill person in which [2] substantial grounds have been shown for believing that he or she…would face a real risk, [i] on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, [ii] of being exposed [a] to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or [b] to a significant reduction in life expectancy".

22. It follows that in Article 3 health cases of this nature, the following questions must be answered in relation to the initial threshold test. First, has the applicant displaced the burden of establishing that he or she is a seriously ill person? This is a relatively straightforward issue and will generally require clear and cogent medical evidence from treating physicians in the UK.

23. The second question is multi-layered. Has the applicant adduced evidence "capable of demonstrating" that "substantial grounds have been shown for believing" that as "a seriously ill person", he or she "would face a real risk":

> [i] "on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment,
>
> [ii] of being exposed
>
> [a] to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering, or

[b] to a significant reduction in life expectancy"?

24. In relation to [ii][a] above, it bears highlighting that it is insufficient for applicants to merely establish that their condition will worsen upon removal or that there would be serious and detrimental effects. What is required is "intense suffering" for the applicant – see [143] of Savran.

25. As set out above, it is for the applicant to adduce evidence capable of demonstrating substantial grounds for believing that he or she would be exposed to a real risk of [a] a decline in health resulting in intense suffering or [b] significant reduction in life expectancy. The nature and extent of the evidence that is necessary will depend on the particular facts of the case.

26. Generally speaking, whilst medical experts based in the UK may be able to assist in this assessment, many cases are likely to turn on the availability of and access to treatment in the receiving state. Such evidence is more likely to be found in reports by reputable organisations and/or clinicians and/or country experts with contemporary knowledge of or expertise in medical treatment and related country conditions in the receiving state. Clinicians directly involved in providing relevant treatment and services in the country of return and with knowledge of treatment options in the public and private sectors, are likely to be particularly helpful.

27. However in this connection we note the observation in Paposhvili (at [186]), as applied in Savran (at [146]) that "a certain degree of speculation is inherent in the preventive purpose of Article 3 and that it is not a matter of requiring the persons concerned to provide clear *proof* of their claim that they would be exposed to proscribed treatment".

28. It is only after the threshold test has been met and thus Article 3 is applicable that the returning state's obligations listed in [187-91] of Paposhvili and summarised at [130] of Savran become of relevance – see [135] of Savran.

29. With these principles firmly in mind, we now turn our attention to the evidence which is before us.

EVIDENCE

The Appellant

30. The Appellant has provided a witness statement dated 17 August 2021 ([CB/1-8]). He also gave oral evidence before us.

31. We regret we did not find the Appellant to be a credible or reliable witness in many respects. In places, his oral evidence contradicted his written evidence, for example in relation to whether his father or brother know of his illness (see §49 of his statement compared with his several oral assertions that they do not know). He was also inconsistent in his various answers in oral evidence. Having said that his father and brother did not know of his illness, he explained that only his wife knew. He later

said that only his wife, his representatives and those in court knew. However, he then expanded this to say that both of his other partners (the two mothers of his second, third and fourth children) knew.

32. At times, we consider that he embellished his evidence. For example, he spoke of the impact his offending, imprisonment and illness has had on [N] and referred to her trying to take her own life. He expressed remorse for having put her in that situation. The way in which he sought to portray that incident was as one which had happened relatively recently. Her witness statement however makes clear that this happened about fourteen years ago, in 2008. Whilst we can well accept that the Appellant's actions and illness have had a significant impact on [N], we consider that the Appellant's oral evidence on this point was deliberately designed to suggest that either [N] would be unable to cope without him or [N]'s own mental health somehow explained his own failure to attend his HIV appointments. We remind ourselves of course that we are not concerned with Article 8 ECHR and so the evidence may have little significance, but this is but one example of the instances where we found ourselves unable to accept the Appellant's evidence.

33. We have already noted that the Appellant was convicted in 2021 of offences committed in 2019. In re-examination, when asked whether he had committed any other drug offences after 2019, he gave an unsatisfactory answer saying "I don't think so, not to my knowledge." This tends to suggest that the Appellant may well not have stopped offending but was unwilling to admit to it. As Mr Malik fairly said during the course of his submissions: he could not pretend that the Appellant had changed; his oral evidence was less than perfect; he departed from his witness statement. Mr Malik accepted that the Appellant is precisely the sort of individual whom the public does not want to see remain in the UK due to his criminal offending and disregard for the law. We entirely accept Mr Malik's reminder that this matters not for the purposes of Article 3, which is clearly an absolute right. However, the Appellant's inability to distance himself from criminal offending made him an unsatisfactory witness and this undermines his evidence.

34. For those reasons, where there is any discrepancy between the documentary evidence and the evidence of the Appellant, we have relied on the former (subject to one point about the Appellant's medication which was subsequently established to be correct by a further document). We consider the substance of his evidence in relation to the issue we have to determine in more detail below.

The Appellant's Wife [N]

35. [N] has provided a witness statement dated 26 August 2021 ([CB/9-12]. She too gave oral evidence.

36. In general, we accept [N]'s evidence. We accept that she intended to be honest. However, we were conscious that, at times, her loyalty to the Appellant made her hesitant or evasive in her answers.

37. In particular, [N]'s written statement was not as complete as it ought to have been. She discloses in her statement that she is in receipt of universal credit ([§14]). She says therefore at [§18] that she could not support the Appellant financially as she "barely survive[s]". Whilst we have no reason to doubt that [N] now receives universal credit and may be on low income, she failed to mention in her statement that she has been working. It emerged in the course of the evidence of the Appellant and her own evidence, that she had worked for three or four years before the Covid-19 pandemic as a bar manager, that she was furloughed during the pandemic and that she now works part-time for Amazon. However, in answer to the first question asked of her at the hearing, whether she had any income besides universal credit, she said that she had not. That was not truthful.

38. [N] was also asked about her evidence at the time of an earlier appeal by the Appellant (in 2007) when she is recorded as saying that the Appellant had "some cousins" in Zimbabwe (§ 26 at [CB/179]). She said that she did not remember saying this. We do not place any weight on her inability to remember. It was a long while ago. We were though slightly concerned by her assertion that she did not know that the Appellant had cousins and, when asked about his grandmother in Zimbabwe (now deceased), she appeared to backtrack from evidence that his grandmother had been living in Zimbabwe and then in relation to children who the Appellant's grandmother may have been caring for. We gained the impression that she was concerned she might be accepting that the Appellant had some family members in Zimbabwe, whether that is the case or not.

39. Again, we deal with the substance of [N]'s evidence so far as relevant to the issue we have to decide below.

Expert Evidence

Dr Gail Crowe

40. Dr Crowe is a consultant physician who is currently treating the Appellant. She is based at the Chelsea and Westminster Hospital although she treats patients also at external clinics. She has written reports in the form of letters which appear at [CB/94-105] dated 31 May 2020, 22 December 2020, 20 April 2021, 12 August 2021 and 29 November 2021.

41. We found Dr Crowe to be an impartial, impressive and wholly reliable witness. For example, although she refers in her letter of 12 August 2021 to the Appellant being diagnosed HIV positive in 2005, she accepted when referred to a letter from Kent Community Health NHS Trust dated 10 May 2013 ([RBS/91-92]) that she might be wrong about that, and it might have been 2003. She also accepted that she might be wrong about the date when the Appellant started taking ARV. She says that it was January 2013 whereas a letter from Kent Community Health NHS

Trust states it to be 2012. Nothing turns on that, but it is an indication of her willingness to accept what were possible inaccuracies in her papers .

42. In general terms, Dr Crowe has treated the Appellant since he reattended her service in January 2018 upon his release from prison. She is therefore very well placed to provide an opinion on his history so far as within her knowledge, his current medication and treatment and the likely effects of any change in medication and treatment. We deal with the substance of her evidence in relation to the issue we have to consider below.

43. In the course of her evidence, we asked Dr Crowe if she would be able to provide a list of the appointments which the Appellant had attended and not attended as she gave evidence that he not infrequently missed appointments. She very helpfully provided that information to us on the morning of the last day (prior to oral closing submissions). We are grateful to her for her assistance.

The Zimbabwean Experts

44. We have received some assistance from two experts, Professor Norman Zimunda Nyazema on behalf of the Appellant and Professor C E Ndhlovu on behalf of the Respondent. Unfortunately, the material was not of as much assistance as it might have been for reasons we set out later. However we were in the end able to glean adequate information (as is also set out) in particular from the expert called on behalf of the Respondent whose experience was of more relevance both as to scope and as to time.

45. Professor Nyazema's first report is dated 26 August 2021 ([CB/32-48]. His CV is at [CB/23-31]. He is currently a research associate at the University of Limpopo. He is a professor of Clinical Pharmacology at various universities. He is an academic who has been involved and published in many areas of Clinical Pharmacology. He was part of a team responsible for drafting Zimbabwe National HIV/AIDS policy and establishment of the National AIDS Council ("NAC"). This was at a time when he was Chairman of the National Medicines and Therapeutics Policy Advisory Committee ("NMTPAC"). He says in his report that at this time it was proposed that there be a sub-committee to deal with ARV which would be tasked with providing guidelines. Unfortunately for reasons we will come to, it is not clear from that section of the report or indeed his extensive CV when that was as he merely says that he was the "former chairman".

46. Professor Ndhlovu's first report is dated 15 November 2021 and is at [CB/106-114]. Her CV is contained within her report. She is a Bachelor of Medicine and Surgery, a Master of Medical Science (clinical epidemiology), a fellow of the Sub-Saharan Africa Regional Institute and of the Royal College of Physicians in London. She joined the University of Zimbabwe as a lecturer in 1992 and conducts "medical education

activities", runs a medical ward and conducts health related research. In 2004, she set up a HIV clinic in Parirenyatwa, Harare. She has also been the chairperson since 2000 of NMTPAC (which Professor Nyazema chaired in the past). As a result, and as we will come to, she has been involved in the review of national ARV guidelines and the development of case management guidelines for Covid-19.

47. At the Tribunal's instigation, the experts were asked to meet and to provide a schedule of those areas where they agreed and disagreed and a joint statement setting out their divergent opinions with an explanation of their respective opinions. The schedule which they provided ("the Schedule") is at [CB/13-17] and their joint statement ("the Joint Statement") at [CB/115-118].

48. As is evident from the Schedule and the Joint Statement, the main areas of disagreement concerned the cost of the medication which the Appellant currently takes were he to seek to obtain it at his own expense in Zimbabwe, the extent of free treatment in Zimbabwe, the risks involved with switching ARV and the monitoring and treatment which would be needed and its cost. In relation to issue [7], concerning the availability of national social security, Professor Ndhlovu had commented that it was "not clear on what basis Professor Nyazema is offering an opinion on this issue" because "[i]t appears to be outside his expertise". We view what is said about this in the Joint Statement to be merely an acceptance by Professor Ndhlovu of the basis of Professor Nyazema's claimed expertise rather than an acknowledgement by her that he is expert in such matters.

49. This brings us on to a concern which we have about the expert evidence from both experts. Neither expert provides any sourcing for their comments. As a result, it is difficult to discern what is evidence on which the Tribunal can place reliance as falling within the expertise set out in the reports, what is material that relies on other sources, or what is merely an opinion unsupported by any expertise of the expert. This failure made the task of the Tribunal more difficult than it ought to have been.

50. To take by way of illustration the point we have referred to above, Professor Nyazema is said to have relevant expertise due to his work with the NAC and organisations dealing with HIV/AIDS and having been part of the team that developed the Zimbabwe National HIV/AIDS policy. He also refers to his expertise derived from his position as former chair of NMTPAC and the Medicines Control Authority of Zimbabwe. We have already observed that he has not said when he held those roles. Professor Ndhlovu has been the chair of NMTPAC from 2000. It must be some considerable time therefore since he was in that role. We however, are concerned with the situation now, and the present position.

51. Issue [7] as identified in the Joint Statement appears to relate to [§56] of Professor Nyazema's report ([CB/46]) that there is no national social security system as there is in the UK and that the Appellant would not be

able to source the national fund because he has not paid into it. It is entirely unclear to us how any of the roles which Professor Nyazema has held (even if they were current) entitle him to express an opinion on this subject nor on the subject of societal discrimination and prejudice, availability of accommodation or employment which is also dealt with in this section of the report. We fail to understand how his role as a health journalist or director of a pharmaceutical company operating in Zimbabwe gives him *expertise* in these areas. If he relies on others for these views, he needed to say so. If he relies on documentary evidence such as media reports or government documents, he needed to refer to those. As it is, we cannot accept his unsourced views on matters outside his stated area of expertise.

52. In any event, we do not need to deal with Professor Nyazema's views about these matters as the Appellant does not raise a claim of destitution on return per se, albeit we of course accept that the requisite analysis must involve a practical assessment of this particular Appellant's circumstances in Zimbabwe. Nonetheless, we find the expression of these views based on some professed expertise which is not evident from his CV to be troubling.

53. Although Professor Ndhlovu has limited the comment in her report to the issues before us and has not strayed beyond her area of expertise, we also have some concerns about the lack of focus in her report. Her report is similarly unsourced by reference to documents. This led to a dispute which emerged late in these proceedings that could have been avoided by clarity of language and reference to documents, as we set out below.

54. Professor Ndhlovu refers in her report to "specific Antiretroviral Therapy guidelines for Zimbabwe (last hard copy dated 2016)" (hereafter referred to as "the Guidelines") and to an "addendum circulated in 2019". The Appellant initially objected to the inclusion of the Guidelines in the consolidated bundle. As the Tribunal indicated however at a case management review, there could be no objection to the inclusion of a document referred to by an expert. The Guidelines appear at [RBS/1-125]. The Guidelines are referred to in more detail in the Schedule under "Issue [6]" which concerns the availability of monitoring and testing to deal with any side effects arising from a switch of ARV.

55. The Respondent's skeleton argument referred to the Guidelines in the context in which they were raised in the Schedule. This led the Appellant to seek further evidence from his expert. Professor Nyazema produced a second report dated 7 February 2022 ([ABS/1-7]) in which he stated that the "level of care and monitoring [set out in the Guidelines] is only on paper when it comes to the public sector". He referred to a conversation he had with the CEO of the NAC, Dr Madzima, who also said that he was not aware of the Guidelines and is said to have indicated that they "do not formulate as the official national guidelines on Zimbabwe on the treatment and monitoring of HIV/AIDS in the public sector". Dr Madzima referred Professor Nyazema to the annual reports of the NAC which, whilst helpful as providing a general overview of HIV/AIDS treatment in

Zimbabwe, provide no assistance on the issue of frequency of monitoring and testing nor do they include any alternative guidelines or reference to any.

56. In response, Professor Ndhlovu provided a further report dated 8 February 2022 ([RBS2]) annexing a further but slightly differently numbered copy of the Guidelines. She insisted that the Guidelines were observed by clinics in Zimbabwe. In response to Professor Nyazema's second report, she said that he had not asked "the appropriate people" for the Guidelines "ie those heading the Directorate of Pharmacy Services or the AIDS and TB Unit". She went on to say that the "NAC is not responsible for developing nor revising the ART guidelines". She also said that NMPTAC is "responsible for the development of national standard treatment guidelines" (including the Guidelines). Professor Nyazema held that position in the past but not at the date of the Guidelines. However, Professor Ndhlovu suggests that Professor Nyazema should have been aware of NMPTAC's role in this regard. Professor Ndhlovu also refers to her role as a clinician supervising the HIV clinic to which we have already referred. She says that she was responsible for producing the first version of the Guidelines in 2003 (which may explain why Professor Nyazema was unaware of them). She also says that Dr Madzima may similarly be unaware of them because NAC is not represented in NMTPAC.

57. Both parties made unopposed applications to adduce these further reports. We therefore agreed to allow them to be included in evidence notwithstanding their late production.

58. Professor Nyazema took the opportunity to reply yet again to Professor Ndhlovu's second report in an email dated 8 February 2022. Although we have read that, we place very limited weight on it. Again, he offers no source for his somewhat strident comments that the Guidelines are "not followed definitely in the public sector" (his emphasis). He refers again to the strategy and oversight documents which themselves contain no guidance as to how treatment is to be administered. He unhelpfully criticises Professor Ndhlovu as "totally misinformed" about the role of the NAC but then appears to agree with her that it is not represented on NMTPAC. He similarly criticises her in relation to her understanding of the structure of "the Ministry" and says that Dr Madzima is "the best person to ask because he is at the coal face" (but gives no information about his experience in his role as CEO) but then says that "[t]he people in the Ministry are basically administrators who rely on information from NAC which also carries out research". He refers to research being undertaken by "a postgraduate student" (unnamed) without including direct evidence from that student. We were very concerned by the tone of this email not least his final sentence that he "rest[s] his case". That is not the tone expected of an impartial and independent expert.

59. In the light of Professor Nyazema's questioning of the interaction between the various organisations and the documents produced by them, we directed Professor Ndhlovu to assist us by providing a diagram

to explain this. That was introduced into evidence on the final day of the hearing and prior to the oral closing submissions. However, we did not need to have it explained to us because in the course of the closing submissions, it became apparent that there was agreement between the parties notwithstanding the somewhat loose language used by the experts. In particular, it seemed to us that whilst the Guidelines advocate close monitoring, and frequent clinic visits, that is not obviously in the context of the frequency of viral load and CD4 testing.

60. Mr Malik indicated at the outset of his reply to the submissions on behalf of the Respondent that he was able to agree the position that the Guidelines might provide for more frequent *monitoring* but did not deal with more frequent *testing* than that which was agreed between the experts in the Joint Statement. Altogether, the expert evidence was of less assistance to the Tribunal (or indeed the parties) than it ought to have been as we have stated. A last minute flurry of exchanges could, with better focus, have been avoided.

61. We make one final, more general observation about expert evidence in "health cases" such as this. Whilst this Tribunal is more used to having before it, experts who are academics in their field, the sort of expert evidence which is likely to be more useful to it in "health cases" is from clinicians directly involved in providing relevant treatment and services in the country of return and with knowledge of treatment options in the public and private sectors, and evidence of expertise at a reasonably contemporary date.

62. Notwithstanding our criticisms of some of the expert evidence in this case, we have derived sufficient assistance to form a view, and have fortunately been assisted by the agreement between the experts on many of the factors we have to consider when determining the issue.

SUBMISSIONS

63. Both parties provided us with written submissions which they expanded upon orally on the second day of the hearing.

64. Mr Malik reminded us that we needed to assess whether in practice the Appellant would be exposed to a real risk of being subject to treatment contrary to Article 3, and that this assessment would need to include the extent to which he will actually have access to the treatment he needs with reference to its cost, the existence of a social and family network and geographic location. Mr Malik focused his submissions on the availability of monitoring and testing in Zimbabwe. He submitted that it was not sufficient for this Appellant to be tested only six and then twelve months after a change in medication. He drew attention to the conflict between the experts on the issue of monitoring and invited us to find that this conflict gave rise to a serious doubt, the benefit of which should be given to the Appellant with the consequence that the Respondent was obliged to obtain individual assurances.

65. Mr Dunlop relied upon his comprehensive written closing submissions. He accepted that the Appellant is seriously ill and we could therefore move swiftly to the second question of whether there is a real risk of a serious rapid and irreversible decline in his health resulting in intense suffering upon return to Zimbabwe. He invited us to find that there is no real risk of the Appellant refusing or failing to take the ARV available in Zimbabwe and in the unlikely event that he required additional monitoring and testing over and above that available in the public sector, this could be funded by his family in the UK, including his very loyal and supportive wife.

66. After hearing detailed submissions from both parties, we reserved our decision.

DISCUSSION

67. Although the Appellant's illness is currently well controlled by ARV, it is accepted by the Respondent that the Appellant is seriously ill. Without appropriate treatment, his immunity levels could be compromised, and he could become susceptible to "opportunistic infections" meeting the relevant threshold and/or is likely to die earlier than would be expected as a result.

Treatment in the UK

68. We begin our analysis with the evidence about the treatment which the Appellant has received and currently receives in the UK.

69. The Appellant was first diagnosed as HIV positive during his imprisonment in either 2003 or 2005, when still a teenager. From 2010 to 2018 whilst also in prison, the Appellant was under the care of Dr Mun-Yee Tung, a consultant physician in HIV. Her letter at [RBS/89-90] describes the Appellant's treatment during that period. Until 2011, the Appellant was not prescribed any medication for his condition. However, following tests in late 2011, he agreed to begin taking ARV.

70. On 18 January 2012, the Appellant was initially prescribed an ARV called Atripla which is a combination of Tenofovir, Emtricitabine and Efavirenz (taken as three tablets). However, he experienced side effects which are described by Dr Tung as "vomiting, stomach cramps, dizziness, night sweats and significant loss of appetite". We do not accept the Appellant's evidence that he wanted to kill himself as a result of the side effects he experienced. He was in prison at the relevant time, and we would expect it to have been noted that he was suicidal if the extent of the side effects were so serious. We consider this to be an exaggeration, albeit we accept that the Appellant probably experienced a combination of the unpleasant side effects described by Dr Tung.

71. In any event, according to Dr Tung, and as the Appellant accepted, he was only able to take Atripla for six days and he was not keen to take any other medication. However, in mid-June 2012, the Appellant agreed to start taking Eviplera, which is a combination of Tenofovir, Emtricitabine

and Rilpivirine (in single tablet form). He is reported as having had some "initial mild side effects" but persevered and continued to take that tablet. He had no further side effects when seen by Dr Tung in 2014. He had an undetectable viral load and a CD4 count of 397 cells (Dr Crowe explains in her evidence at [CB/97] that 500-1500 is the count of a generally healthy person but "in general" people are unlikely to become ill until the CD4 count falls below 350).

72. Dr Crowe began treating the Appellant again in January 2018 when he was released from prison (she had treated him before his lengthy conviction, but we do not need to refer to that as he was not prescribed ARV at that time). Dr Crowe records the foregoing history in her letter dated 12 August 2021 ([CB/97-99]). She is of the opinion that it is likely to be the Efavirenz which caused the Appellant's side effects. By the time that she saw him in January 2018, his CD4 count was 543 which was "within the normal limits for someone without HIV and suggests full recovery of his immune system".

73. In terms of medication, the Appellant said that he had been prescribed four different ARVs over time. That was not reflected in Dr Crowe's earlier reports before us. However, her notes provided following her evidence show that the Appellant was in fact switched on an interim basis to another ARV when he attended Dr Crowe's clinic in January 2019. At that stage, he had not attended the clinic since April 2018. He had run out of Eviplera 2 ½ months previously. Dr Crowe records that his CD4 count was 387 and his viral load 135,000 copies/ml. He was switched at that time to "TDF/FTC and Rezolsta". He was given one month's supply. As we understand it from another of Dr Crowe's letters "TDF" is Tenofovir Disoproxil Fumarate and FTC is Emtricitabine. The Appellant's evidence was that this was in the form of three tablets rather than a single tablet.

74. As Dr Crowe explains in her letter of 12 August 2021, as confirmed by her notes, this was merely a temporary switch with a view to a more permanent switch to Symtuza. That switch was not however completed until April 2019 because the Appellant failed to attend appointments arranged for him on three occasions in February 2019. On 27 February 2019, the Appellant phoned to say that he had run out of the medication prescribed in January 2019 and [N] collected a further month's supply of the temporary three tablets medication.

75. The Appellant attended Dr Crowe's clinic on 15 April 2019 and was given two months' supply of Symtuza. He did not attend again until 17 July 2019 (having run out six days previously). He was given a further three months' supply. He did not attend Dr Crowe's clinic again until 27 November 2019. He failed then to attend appointments arranged in February and April 2020 (even though he had been booked for a blood test also on 21 April 2020). Having run out of medication, he attended the clinic on 11 May 2020 and was given five months of Symtuza. He did not attend the clinic again until December 2020 when he was given six months of Symtuza.

76. In her letter of 12 August 2021, Dr Crowe reports that, when seen in December 2020, the Appellant's viral load was undetectable and his CD4 count was 478. She records that he continued to miss clinic appointments "on a frequent basis" but that "when he has medication, he takes it consistently and his blood results back this up". That is consistent with Dr Crowe's notes, which show that the Appellant attended an appointment in May 2021 but was not seen again until February 2022 when he was "seen at court" and given three months of Symtuza.

77. Notwithstanding what Dr Crowe describes as the Appellant's "chaotic" adherence to his monitoring regime, she says in her letter of 12 August 2021 that his "physical health is fairly good". He is recorded as having a healthy BMI but if he lost more weight due to unavailability of food, that would have a negative impact on his health.

Treatment in Zimbabwe

78. We turn then to the evidence we have about the treatment in Zimbabwe which the Respondent accepts, in a health case of this nature involving a sophisticated medication regime, includes not only accessibility to ARV but accessibility to monitoring and testing.

79. Before we turn to the specifics of the Appellant's case, we record the evidence demonstrating that notwithstanding many economic and political challenges over time (as recorded in the country guidance cases on Zimbabwe that we have reminded ourselves of), Zimbabwe has made enormous strides in the management and care of HIV/AIDS. The NAC report for 2020 (at [ABS/8-40]) as produced by Professor Nyazema, records that 84.7% of those living with HIV are receiving ARV. In some areas, notably for our purposes, testing, the results are not as encouraging. The report notes that only 57.2% of those on ARV are tested for viral load suppression. Nonetheless, the figures in that report and the other reports in that bundle show encouraging progress.

Availability of ARV

80. We deal first with medication. It is agreed between the experts that Symtuza is not a drug registered and available in Zimbabwe. There is some disagreement between the experts about the cost of importing Symtuza. Professor Ndhlovu quotes a figure in the Joint Statement of US$75 per month but that is based only on "verbal communication from one wholesaler". According to the Joint Statement, Professor Nyazema has "heard from reliable sources that pharmacists can put a mark-up of between 30-70% on the wholesale price" which we would find unsurprising.

81. Both experts have assumed in any event that the Appellant would be unable to afford private healthcare to pay for the totality of his treatment. We are prepared to assume that is so. Professor Nyazema

accepts that the amount paid for medication by those who use public healthcare is only US$2.

82. The experts have identified a range of alternatives to Symtuza in the Schedule. We do not need to consider the detail of what is there set out. Dr Crowe has considered the position based on Professor Ndhlovu's report. She suggests that a three-drug combination of TDF, Lamivudine and Dolutegravir (now being prescribed to patients in Zimbabwe as a "first-line" treatment) could be a suitable alternative. This is a "3-in-1" combination and therefore as we understand it a single pill.

83. Dr Crowe considers this option in her letter dated 29 November 2021 ([CB/94-95]). She says that the Tenofovir in Symtuza is "a more 'kidney friendly' version of [TDF]" but that the Tenofovir Alafenamide in Symtuza "is not strictly necessary" as the Appellant has no renal dysfunction. She says that Lamivudine is generally interchangeable with the Emtricitabine in Symtuza. Although she says that Darunavir is "particularly useful in patients who are poorly adherent to medication" and that Cobicistat allows a lower dose of Darunavir to be used, she agrees that the alternative proposed by Professor Ndhlovu "would be a reasonable antiretroviral medication for [the Appellant] to use and would be expected to work effectively". She does say that the long-term efficacy of Dolutegravir is "less certain" (it has been licensed fairly recently in the UK) and that "resistance mutations do arise in a small percentage of patients who have failed Dolutegravir" which is "potentially a source of concern in somebody as chaotic and poorly adherent" as the Appellant. However, she also says that she "would expect this medication to work well". She concludes that the ARV alternatives proposed by Professor Ndhlovu "are reasonable and virologically have a high probability of working well".

84. We accept Dr Crowe's evidence in this regard. The ARV alternative which Professor Ndhlovu proposes is therefore available and is likely to be effective from a clinical perspective. According to Professor Ndhlovu the alternative ARV is available in the public sector and would therefore, according to Professor Nyazema, cost US$2 per month.

Monitoring and testing

85. Dr Crowe's main concern about the medication proposed by Professor Ndhlovu is the risk of side effects and the unavailability of sufficient monitoring and testing following the switch of ARV. Professor Ndhlovu says that the proposed medication can cause "neuropsychiatric side effects" including sleeplessness and weight gain. The latter would not be a concern, but Dr Crowe considers that sleep disturbance would be, particularly given the Appellant's assertion that the side effects of Atripla "almost killed him". We have already indicated that we consider the Appellant's evidence in this regard to be an exaggeration. We are

satisfied that these side effects would not reach the requisite threshold to amount to an Article 3 breach. We need not expand on this as Mr Malik confirmed that this was not the Appellant's case.

86. One of Dr Crowe's main concerns is the extent of the monitoring and testing in Zimbabwe which would be carried out at the time of switching the ARV. We therefore turn to consider this. We have already set out the dispute which arose immediately prior to the appeal hearing regarding monitoring and testing. The parties now agree that these are two separate things. As Mr Dunlop confirmed and Mr Malik accepted, monitoring may include testing but is not confined to it.

87. We begin with what Professor Ndhlovu says in her first report as follows ([CB/112]):

> "If AM is enrolled in the public sector and is given what the public sector has ie tenofovir/lamivudine and dolutegravir, there will be need to monitor his HIV viral load (VL) to ensure that it remains undetectable. Currently the VL testing algorithm requires that the VL be done 6 months after starting ARVs and then at 12 months and thereafter annually. If a particular regimen does not control his VL, he would need to undergo enhanced adherence counselling with our clinic counsellors for a period of 3 months and then have a repeated VL test at the end of those 3 months. If his VL shows suppression, he would then continue on the same regimen indefinitely and be getting his annual VL testing. He may be allowed to pick up his medicines every 6 months supplies permitting."

88. The Guidelines which caused the controversy between the experts say the following ([RBS/51-52]):

> "Chapter 8: Monitoring Patients on Antiretroviral Therapy
>
> Patients on ART need close monitoring to assess adherence to the treatment regimen, tolerance, the side effects of the medications, and the efficacy of the treatment.
>
> …
>
> 8.3 Frequency of Clinic Visits
>
> Initially the patient should be seen every two weeks for the first month after initiating treatment, and thereafter monthly for another three months, then every two months thereafter.
>
> After the first six months, the patient can be seen at reduced frequency depending on whether they are stable or not."
>
> …
>
> There are three main types of clinic visits:
>
> • A clinical visit is a scheduled appointment where the clinician makes a thorough assessment and reviews monitoring blood tests. A stable patient on ART should be seen for a clinical assessment every 6 months.
>
> …"

The Guidelines however specify that testing is, as agreed by both experts, at the six months point and thereafter at twelve months and annually.

89. We have already dealt with the disagreement between the experts about the Guidelines, their existence and relevance to practices on the ground. We accept Professor Ndhlovu's evidence in this regard as her expertise is more relevant to the current clinical situation on the ground in Zimbabwe. We have had regard to Mr Malik's submission that Professor Nyazema's expertise is recognised by Professor Ndhlovu based on what is said in relation to issue [7] of the Joint Statement. We are unable to accept that this is any more than an acceptance by Professor Ndhlovu that her comment about Professor Nyazema's expertise in this area (as set out in the Schedule) was unwarranted. In any event, it is for us to assess the expert evidence and to place the weight on it which we consider to be justified given the respective expertise of the two experts and all the country background information available to us.

90. We also take on board Mr Dunlop's submission about Professor Nyazema's reliance on the National HIV Care and Treatment Strategic Plan 2013-17 ([ABS/114-193]) as support for his assertion that the Guidelines do not apply to the "present day status of the health system which is on its knees". It is difficult to see how a forward looking report produced in July 2013 can pass comment on the system in 2022. That report also pre-dates the Guidelines and is therefore irrelevant to whether the Guidelines are in existence and being operated on the ground. Finally, as Mr Malik very fairly accepted, the documents to which Professor Nyazema has referred in his second report take us nowhere in terms of the testing which is available in the public sector as neither of them comment on the frequency of testing (albeit they do refer to the actuality of testing which is improving – see strategic plan 2015-2020 at [ABS/89-90] – 14% - against the 2020 report at [ABS/22] – 57.2%).

91. We do not accept Mr Malik's submission that we should find that there is no testing available in Zimbabwe or that the impact of the Coronavirus pandemic has significantly disrupted testing to the extent that it remains unavailable. That submission is based on a document disclosed by the Respondent entitled "Response to an Information Request: Zimbabwe: HIV" at [CB/158-161] which states that testing is "temporarily not available" due to the Covid-19 pandemic, it appears because samples had to be sent to South Africa from the laboratories which patients attend in Zimbabwe. Mr Malik made the point that the Respondent had asked for this document to be included in the consolidated bundle. However, in accordance with her duty of candour, we would expect her to do so.

92. The fact that no specific update has been relied upon is nothing to the point. Although the Country Policy and Information Note dealing with medical treatment and healthcare in Zimbabwe dated April 2021 ([CB/119-157] focusses on the availability of medication so far as concerns HIV/AIDS (at [3.13]), there is no indication there that testing cannot take place and we consider that this would have been mentioned

if that remained the position. July 2020 was of course only a few months into the pandemic, and we are unsurprised that at that time laboratories would be unable to carry out routine testing for other conditions.

93. Further, although the NAC annual report to which we have already referred (at [ABS/8-40]) makes the point that testing is below targets, it states at §2.1.6 that 679,506 "clients on treatment" had been tested for viral load suppression albeit that was only 57.2% of those on treatment. Again, we would expect that if testing remained impossible, the report would say so.

94. We accept Professor Ndhlovu's evidence about the existence of the Guidelines and that those are applied in practice. She is a clinician, currently supervising a HIV clinic. Professor Nyazema is neither a clinician nor someone with direct links to those with clinical experience on the ground. We also note that Mr Malik accepted that we should proceed on the basis of the position on testing as agreed between the experts i.e. the Appellant would be able to access testing at public expense six months after being started on a different ARV, thereafter at the twelve months' point and then annually if stable.

95. We begin with the views of Dr Crowe on the level of testing availability. She says that such testing is "not frequent enough; a test performed six months post switch will miss renal and liver dysfunction that has occurred post switch (which is picked up on blood tests) and will also miss side effects such as sleep disturbance and mood changes that may be severe enough to cause a patient to stop their medication".

96. For example, she said in her oral evidence, that when the Appellant was switched to Symtuza, she would have asked him to attend for blood tests after one month (to test for abnormalities), then two to three months later for a blood test and to give more medication and then six months later. That is not entirely consistent with what in fact happened according to her notes. These indicate that the Appellant did not attend the clinic for nearly three months after the switch (April to July) and then a further four months (July to November). Presumably therefore the Appellant could not have had blood tests at the stages which Dr Crowe would ideally have liked. We emphasise that we do not criticise Dr Crowe for her oral evidence in this regard as she did not have her notes with her and was merely recording what she would generally regard as appropriate.

97. In any event, we need to break down Dr Crowe's comment into its component parts. The first part, relating to renal and liver dysfunction, we accept is something which would require a blood test (as would testing of viral load and CD4 count). The observation of side effects though is not. That could, we suggest, be picked up by monitoring. That then is the relevance of the closer monitoring to which Professor Ndhlovu refers in her report and in the Schedule.

Monitoring / testing costs

98. However, even adopting what is said in the Joint Statement that "[c]loser monitoring means laboratory determination of his viral load" and that "[t]he public sector will only cover basic testing (eg viral load once a year once he is stable)", we have to consider whether testing outside the public sector regime is available and accessible (in the sense of being affordable for this particular Appellant). The evidence in that regard comes in Professor Ndhlovu's second report. She says the cost is around US$40. We were not taken to any evidence rebutting that assertion.

99. In his reply to the Respondent's submissions Mr Malik did not dispute the US$40 figure but invited us to note three factors: (i) this is just the cost of one test and more than one test was likely to be necessary; (ii) when assessing affordability, other matters needed to be factored in given the context of Zimbabwe, such as the Appellant's need for shelter and food; (iii) his wife and family would not be able to afford to send money to cover the costs of testing, in addition to support with shelter and food.

100. That brings us to the evidence about the Appellant's means. We have already referred to the evidence provided in written form that [N] is in receipt of universal credit and that this is her only income. In light of the oral evidence, that cannot be accepted. She is currently working part-time for Amazon and has worked in the past as a bar manager. We had no reliable evidence about her level of income, but we are prepared to accept that she is on a low income. Nonetheless, US$40 is not a significant amount and would not have to be paid on a regular basis. We observe that the Appellant went for about three months following the temporary switch of ARV without attending Dr Crowe's clinic and for a further three months following the switch to Symtuza. At most therefore, he might need a few additional tests at any one point in time, besides those available at public sector expense in Zimbabwe. That expense would be several months apart and we conclude would be affordable to [N] even when other adhoc expenses for shelter and food are factored in. We have reached that conclusion having assumed [N]'s income to be low.

101. It was suggested by Mr Malik in his closing submissions that [N] could not be expected to support the Appellant following return to Zimbabwe. [N] would, we accept, not return with him as she has her son and family in the UK. We accept also that it would be difficult for her to afford to visit him and that it would likely be many years before he could ask to re-enter the UK if he still wished to do so. However, [N] has shown considerable loyalty to the Appellant. She has stood by him not only during his lengthy term of imprisonment (and re-imprisonment following breach of his licence conditions) but also knowing that during the course of their relationship and after their marriage, he has had relationships with two other women who have borne his children. We do not accept the submission that she would not continue to support the Appellant on return to Zimbabwe. We think it very likely that she would do so.

102. We were provided with oral evidence from the Appellant that he had managed to pay the fee for the Supreme Court appeal and had also managed to obtain sureties for bail. Both cost in the region of £1000

each. The Appellant's evidence was that [N] had funded the appeal fee via a loan and that the sureties were obtained from [N]'s family. We see no reason why they could not be asked to assist again. We consider it likely that even after his deportation to Zimbabwe, [N] will maintain a close relationship with the Appellant and will be able and willing to provide him with the necessary financial assistance to fund additional testing and monitoring together with other expenses, should that become necessary.

103. Even if [N] and her family would not assist as they have in the past, the Appellant also has family in the UK. His father is unwell, but his brother works as an estate agent. Even if we accept the Appellant's oral evidence that his father and brother do not know that he is HIV positive, we see no reason why he would need to disclose this to them if asking for money to support himself on return to Zimbabwe. We were in any event somewhat sceptical about this evidence, given the Appellant's written statement and changing position about those aware of his illness. We note that there is a high proportion of the population which has HIV but are prepared to assume there remains a level of stigma toward those with the condition. The Appellant's own evidence was that he has successfully kept his condition discreet whilst in the UK. We have not been taken to any evidence that this could not continue in Zimbabwe.

104. Finally and if we are wrong regarding family support, the Appellant is young and according to Dr Crowe's evidence, able-bodied. There is no reason to consider that he is not able to work. Although he has referred to difficulties with his mental health there is no evidence that this would prevent him from earning an income. He has qualifications from prison and is articulate and intelligent. We are satisfied that whilst life in Zimbabwe will be difficult given his lack of connections and the prevailing economic climate, he will be able to generate some form of income in order to provide himself with basic housing and food together with any one-off costs necessitated by further testing.

Treatment in Zimbabwe – Appellant's behaviour

105. We move on to the other reason why Dr Crowe considered that the level of monitoring might be inadequate. As we have already observed, some of her concerns can now be alleviated by the evidence about the closer monitoring (but not testing) available in the public sector in Zimbabwe. Her additional concern was that the Appellant might stop taking his medication if he suffered side effects, as he did when he started taking Atripla.

106. Dr Crowe described the Appellant's adherence to his treatment as "chaotic". As we have already observed, the Appellant has regularly failed to attend appointments made for him in the UK. He not infrequently runs out of medication before he makes contact with the clinic (see Dr Crowe's notes). He was even given medication at court on one occasion because he had failed to attend the clinic to get a supply. We therefore accept that Dr Crowe's assessment of the Appellant's

adherence to treatment in the UK to be a fair one. We must however consider all the evidence holistically in order to determine the Appellant's likely approach to adherence to treatment in Zimbabwe.

107. On occasion, the Appellant sends [N] to collect his medication. It goes without saying that on those occasions, the Appellant's wellbeing cannot be either monitored or tested. Both the Appellant and [N] were asked why the Appellant did not attend appointments. The Appellant says in his statement that he sees Dr Crowe "every 3 months" and that his "bloods are taken and analysed" [§48 of his statement]. By reference to Dr Crowe's notes, that is patently untrue. The Appellant goes on to say at §49 that he has had poor attendance in the past because he "could not afford to travel" and is "even reluctant to attend the clinic". In oral evidence, both the Appellant and [N] accepted that Dr Crowe runs a clinic in Harlow where they live and that is the clinic which the Appellant attends.

108. The Appellant said in his evidence that he had to get a lift to go to his appointments from "whoever is available". He said that he asks whoever gives him a lift to drop him off at the shops so that they do not see him going into the clinic. He said it takes fifteen minutes in the car from his home to the shops. In her evidence, however, [N] said that when she went to collect the Appellant's medication, she would either walk or get a taxi. When asked how far the clinic was from her home, she said it would take her 20-30 minutes to walk.

109. We do not therefore accept the Appellant's evidence that he does not attend appointments because he cannot afford to travel to the clinic. The distance between [N]'s home and the clinic is walkable. In any event, the Appellant's response to the query why affordability was a problem was telling. He accepted that it was "not an excuse" and that sometimes his mental state reaches the point where he blocks out his HIV and medication. He said that sometimes when he is ill, he feels like he cannot handle his condition. When asked whether the reason he did not attend was because he was getting no side effects at the time, he focussed on the position of his children and said that as a result he "put his own care aside". He knew that it was "essential to see Dr Crowe because [he needed] to know his CD4 count". He did not fail to attend because he did not want to take his medication or did not wish to benefit from monitoring and support. He did not miss appointments "on purpose". It was simply that he was "putting others in front". We have considered all the documentary and oral evidence in the round and conclude that the Appellant does not always prioritise his own health but that he is capable of doing so when this become pressing or necessary. In particular, the Appellant has demonstrated a greater reluctance to attend appointments when he feels well but he is able and willing to attend again when he needs medication or starts to feel unwell.

110. Although Dr Crowe says in her letter dated 20 April 2021 ([CB/100-101]) that ARV taken in more than one tablet would not be "the right regimen" for the Appellant because he might forget to take it, the Appellant himself

said that “he was happy to take the tablets”. His concern was what the ARV did to him. In other words, it is his experience of Atripla which has caused him concern about an ARV which involves taking more than one tablet and not the fact of the ARV involving the taking of more than one single pill. He said that if his “body agrees [with the tablets] he would take them to keep himself alive”. We also observe that before he was switched to Symtuza, the Appellant was prescribed an ARV involving three tablets (as the Appellant confirmed in his evidence). Although we accept that this was on a temporary basis for no doubt good clinical reasons, the Appellant was not seen by Dr Crowe in her clinic for almost three months after the switch (due to the Appellant’s failure to attend appointments in February). That is consistent with the evidence which we have that the Appellant does not always adhere to his treatment plan in the UK when he feels well but returns when he starts to feel unwell and/or has run out of medication.

111. We have concluded on the evidence that the Appellant is intelligent and resilient. He has demonstrated significant insight into his medical condition over a lengthy period of time. Although he has described feeling low and upset regarding his HIV condition and other personal circumstances, he has been able to rise above these to the extent that is necessary to access the medication he needs. This includes a challenging period in prison. We are entirely satisfied that the Appellant is aware of the need to take his medication and for regular monitoring and testing. He has actively sought it out when he needs to or starts to feel unwell. We conclude that notwithstanding Dr Crowe’s evidence that the Appellant is chaotic and poorly adherent to his treatment in the UK, he would be pro-active regarding his treatment in Zimbabwe and would seek out the treatment he needs, including any necessary further monitoring and tests unavailable in the public sector.

112. We bear in mind that the Appellant’s circumstances in Zimbabwe will be very different to those pertaining in the UK. He will not have day to day support from his wife [N] and is likely to miss his children and family in the UK. Whilst he is likely to face challenges in Zimbabwe, we are satisfied that he has the mental strength to overcome these and the physical capacity to secure an income. We note there is no medical evidence that the Appellant suffers from depression or is at risk of developing serious mental health symptoms in Zimbabwe. Dr Crowe mentioned in her letter dated 12 August 2021 that he has been encouraged to engage with his GP and to discuss anti-depressants. We have not been provided with any evidence that he has done so.

113. Although the Appellant is not regulated and reliable in his attendances for treatment in the UK, it is clear to us that he does not attend because he prioritises other matters and that if he starts to feel unwell or runs out of medication, he again seeks treatment. Although we would accept based on the Appellant’s oral evidence, that he continues to struggle with his diagnosis, he is by his own admission aware of the need to continue to take medication and to be tested. We have no doubt that the

Appellant is able and willing to prioritise his HIV condition in Zimbabwe to the extent that is necessary to ensure he gets the treatment he requires. We have also concluded that the Appellant could obtain the limited financial support which he might need in the short term to test for any reaction to a change in ARV either from [N], her family or from his brother in the UK.

114. In our judgement, there is no realistic prospect of this Appellant refusing to take his medication or failing to prioritise his health in Zimbabwe. He may have been chaotic in the past but he has clearly calculated that this was a viable option for certain periods. When it is necessary to be pro-active about treatment he knows to be necessary, there is ample evidence to demonstrate that the Appellant is able to be sufficiently organised to access that treatment. This is not a case where the Appellant suffers from any mental or physical condition which would prevent him from recognising the importance of treatment nor which impacts on his capacity to make an informed choice.

115. We do not therefore need to deal with the Respondent's submission that the immediacy of any impact arising from the change in ARV would not be sufficient. It might well take many months for there to be an impact on the Appellant's health and many more months or even years for that to translate into the seriousness of suffering to reach the requisite intensity of suffering. We are satisfied for the reasons that we have already provided that this Appellant will be able to obtain the requisite treatment (including monitoring and testing) to obviate such a deterioration in his health if such a point arises.

116. However, for the sake of completeness, we turn to the evidence about what would happen if the Appellant stopped taking his medication temporarily or permanently.

117. In 2012, following the side effects which the Appellant suffered from Atripla, he stopped taking ARV for a period of about four months. The Appellant said in his evidence that this could not have been the case as he would have been "skin and bones". Once he started taking medication, he could not stop taking it. We do not accept that Dr Tung is wrong about this. According to Dr Tung's letter ([RBS/133-134]), after about three months without ARVs following the Appellant stopping Atripla, his CD4 count had fallen to 245 cells: that is a precise record, supporting clinical measurement.

118. In any event, the Appellant accepted in his oral evidence that he stopped taking Eviplera in 2018/2019. Dr Crowe's evidence is that it was his failure to take his medication for two months which led to the change to Symtuza as he could not simply re-start Eviplera after that period. Dr Crowe says in her letter dated 12 August 2021 ([CB/97-99]) that, in January 2019, when the Appellant reattended her clinic after 2½ months without Eviplera and feeling unwell, his viral load was 135,000 copies and his CD4 count was 387. She accepts that the CD4 count was still above the 350 threshold at which HIV related illnesses generally occur.

119. We accept, however, Dr Crowe's oral evidence that simply because the Appellant has not suffered immediate, significant deterioration in his health when untreated for a few months in the past, that this necessarily reflects what the position would be upon return to Zimbabwe. In her letter dated 12 August 2021 ([CB/97-99]), she says that if the Appellant did not receive appropriate ART, it would be highly likely that he would suffer a deterioration in his health "within a few years" (the reference there to "highly unlikely" is we accept a slip). She goes on to say that "[i]n untreated patients the average time between acquisition of HIV and development of an AIDS defining illness is 11 years" and "[i]f an AIDS defining condition is not treated appropriately then death usually occurs within a year". As she says and we accept "[u]ntreated HIV disease is still a universally fatal condition".

120. We do not need to say more about this as the Respondent's primary case is that there is medication which is available and accessible (including being affordable). We have accepted that to be the position and the issue does not therefore arise. Mr Malik accepted that if the Appellant experiences side effects from a change in medication, those would not reach the necessary threshold to succeed in his appeal. It is the consequences of the change in medication, any side effects resulting from that change and the Appellant's reaction to them which the Appellant says would meet the relevant threshold.

APPLICATION OF CONCLUSIONS TO THE ISSUE

121. We deal with the issue based on the component parts of the test as set out at [21] above (itself based on the way in which it was approached in submissions). First, has the Appellant displaced the burden of establishing that he is a seriously ill person? Second, has the Appellant adduced evidence "capable of demonstrating" that "substantial grounds have been shown for believing" that he "would face a real risk":

> [i] on account of the absence of appropriate treatment in Zimbabwe or the lack of access to such treatment,
>
> [ii] of being exposed
>
> [a] to a serious, rapid and irreversible decline in his state of health resulting in intense suffering, or
>
> [b] to a significant reduction in life expectancy?

(1): Is the Appellant a seriously ill person?

122. This is conceded by the Respondent even though the Appellant's condition is currently well controlled. We accept that concession.

(2[i]): Is there appropriate and accessible/affordable treatment in Zimbabwe?

123. We have concluded that there is. We do not rely on the possibility of the Appellant importing Symtuza. Whatever the cost, we accept that this is unlikely to be affordable. We focus on the alternative medication, which

was put forward by Professor Ndhlovu, not disputed to be available or accessible by Professor Nyazema and more importantly accepted by Dr Crowe to be one which has a "high probability of working well". That is a 3-in-1 combination of Tenofovir, Lamivudine and Dolutegravir.

124. Assuming that the Appellant does not experience side-effects to this medication, the point about the need to take three tablets instead of a single pill does not arise. Even if the Appellant has to switch from a single pill to two or even three tablets until he finds an alternative ARV which suits him, we have concluded that he would take the medication. His aversion to three tablets is based on the side-effects he experienced when he took Atripla. He has taken more than one pill in the past (between Eviplera and Symtuza) and was broadly adherent (and does not say that he experienced any side effects). He gave evidence that he would take his tablets, recognising their importance, unless his body had an adverse reaction to them.

125. The Appellant does not suggest that the side effects which he might experience following a change of medication are so extreme that those would meet the threshold which we have to consider. That concession is rightly made. Even if the Appellant experiences those symptoms, they would not be sufficient to meet the requisite threshold. The main side-effects said to arise from the ARV proposed and available in Zimbabwe are sleep disturbance and weight gain. We have rejected the Appellant's evidence that taking Atripla nearly killed him. Whilst we accept that the reaction which he experienced was very distressing for him, it would not itself reach the threshold.

126. Neither do we accept that such symptoms would lead the Appellant to cease taking the medication. He experienced mild side-effects from Eviplera but continued to take it for a number of years. He agreed to take a different ARV even when he faced the more serious side-effects from Atripla, knowing that if he did not take another ARV, he faced more serious consequences arising from his condition.

127. Turning then to the available monitoring and testing, we assume the position to be as the experts had agreed that there will only be one test after six months of switching and then at twelve months and annually thereafter. We accept that this is less frequent than that offered by Dr Crowe in the UK.

128. However, although Dr Crowe's view is that this is an insufficient frequency of testing at the outset, the Appellant has not in fact attended her clinic for tests at the frequency she would ideally recommend . Monitoring is in any event more frequent (according to Professor Ndhlovu and the Guidelines which we accept do exist on the ground) and in fact more frequent than that advocated by Dr Crowe. Monitoring would identify side-effects although we accept would not be able to test either liver or kidney function nor (we assume) the efficacy of the medication (which requires viral load and CD4 count testing). However, we are not required to consider the difference in treatment based on a benchmark of

what is available in the UK but what is necessary to control the Appellant's illness. In that regard, we note that the Appellant's condition has been controlled notwithstanding his failure to attend appointments as regularly as he should in the UK and having run out of medication on several occasions (including several months in 2018/2019).

129. We proceed in any event on the assumption that the Appellant may well need at the outset to obtain more tests in the private sector in order to ensure that his viral load and CD4 count are monitored to test the efficacy of the new medication and for blood tests to monitor his liver and kidney function. We have concluded that the Appellant could generate his own income in Zimbabwe and in any event will be able to turn to financial support in the short term from [N] who would be willing to continue to support him, to her family who have assisted in the past and to his brother (who would not need to be told why he needed the money even if he is unaware presently of the Appellant's condition). For the avoidance of doubt, we have assumed that the Appellant will not have family members to turn to in Zimbabwe and is likely to be living in difficult circumstances bearing in mind the prevailing economic climate in Zimbabwe and the fact that he has not lived there since leaving as a child. Notwithstanding his difficult circumstances in Zimbabwe the treatment generally available there will be sufficient, appropriate and accessible in practice for the treatment of the Appellant's HIV.

130. In conclusion, treatment to avoid a breach of Article 3 ECHR is available and accessible in Zimbabwe. Assuming a certain degree of speculation is inherent in the preventative purpose of Article 3 and that it is not a matter of requiring the person concerned to provide clear proof of his claim that he would be exposed to proscribed treatment, we are not satisfied that in the present case the Appellant has shown substantial grounds for believing that he would face a real risk of a serious rapid and irreversible decline in his state of health resulting in intense suffering or a significant reduction in life expectancy. This is because on the evidence available the Appellant will have access to a suitable alternative ARV and the other associated treatment required i.e. adequate monitoring and testing, in order to obviate a real risk of a serious rapid and irreversible decline in his state of health resulting in intense suffering.

131. If the Appellant ceased to take medication because he was suffering from adverse side-effects, we have concluded above that he would be able to access alternatives via the public sector in Zimbabwe.

132. For the reasons we have already set out we do not accept that the Appellant will not prioritise his health in Zimbabwe when necessary. However, if the Appellant ceases to be adherent to treatment, that would be his choice. Any impact from that failure to adhere to treatment would not be "on account of" or for reasons relating to the absence or inaccessibility of treatment but his own refusal to adhere to it. There would therefore be an absence of a causal link and no breach of the Appellant's Article 3 rights occasioned by his removal to Zimbabwe by the Respondent.

(2[ii] [a] and [b]): Would there be a real risk of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or a significant reduction in life expectancy?

133. Given our conclusion regarding the availability and accessibility of treatment in Zimbabwe, we do not need to reach any conclusion about this. We would not have decided this appeal on the basis that a deterioration in the Appellant's condition would not be sufficiently immediate were treatment not available or accessible. The lack of appropriate treatment would in any event, we accept, impact on the Appellant's life expectancy. Absent appropriate treatment, we accept Dr Crowe's evidence that it is inevitable that the Appellant would die, and we accept that this would happen sooner than would be the case with treatment.

Are there therefore substantial grounds for believing that there is a real risk of a breach of Article 3 ECHR?

134. We answer this question in the negative for the reasons set out above. The Appellant will be able to access alternative but suitable ARV and associated treatment in Zimbabwe. He may have to pay for some testing and a very small sum for medication but that will be affordable to him given the sums involved and his ability to turn to the support of his wife, her family and his own family in the UK.

CONCLUSION

135. For the foregoing reasons the Appellant's appeal is dismissed.

DECISION

The Appellant's appeal is dismissed on human rights grounds (Article 3 ECHR). The Appellant's appeal on Article 8 grounds was finally dismissed by this Tribunal by decision promulgated on 19 May 2015.

Signed: The Hon Mrs Justice Foster Dated: 22 March 2022
Mrs Justice Foster