IN THE UPPER TRIBUNAL
IMMIGRATION AND ASYLUM CHAMBER

Case No: UI-2022-003252
First-tier Tribunal No: HU/02886/2020

THE IMMIGRATION ACTS

Decision & Reasons Issued:
On the 25 May 2023

Before

UPPER TRIBUNAL JUDGE MANDALIA

Between

Wilfred Batsirai Mbanga
(NO ANONYMITY DIRECTION MADE)

Appellant

and

Secretary of State for the Home Department

Respondent

Representation:
For the Appellant: Ms S Aziz, Counsel instructed by Tann Law Solicitors
For the Respondent: Mr P Lawson, Senior Home Office Presenting Officer

Heard at Birmingham Civil Justice Centre on 11 May 2023

DECISION AND REASONS

1. The appellant is a national of Zimbabwe. On 6 February 2020, the respondent made a decision to refuse to revoke the deportation order signed by the respondent on 9th August 2016 and to refuse a human rights claim made by the appellant. The appellant's appeal against that decision was dismissed by First-tier Tribunal Judge Young-Harry for reasons set out in a decision promulgated on 5 May 2022. The appellant was granted permission to appeal to the Upper Tribunal and the decision of Judge Young-Harry was set aside for reasons set out in my error of law decision issued on 17th March 2023.

2. I directed that the decision will be remade in the Upper Tribunal. In paragraph [12] of my error of law decision I set out the findings made by Judge Young-Harry which were not challenged by the appellant, and which are preserved. I shall return to them later in this decision. I set out the scope of the narrow issue that remains to be resolved. I said it will be for the Upper Tribunal when it remakes the decision to determine whether the medical evidence before the Tribunal taken together with the background material relied upon by the parties is capable of establishing that:

    a. there would be very significant obstacles to the appellant's integration into Zimbabwe because of his health;

    b. there are very compelling circumstances for the purposes of s117C(6) of the 2002 Act.

    c. the decision to refuse to revoke the deportation order and to refuse the appellant's human rights claim is contrary to Article 3 by reference to the test set out in AM (Zimbabwe) v SSHD [2020] UKSC EWCA Civ 64

Application for an adjournment

3. At the outset of the hearing before me Ms Aziz confirmed that as far as she is aware, no further evidence has been filed and served on behalf of the appellant. She submitted that despite the absence of a witness statement or any further evidence, the appellant should be permitted to give oral evidence and provide the Tribunal with an update as to his current medication. She invited me to stand the matter down so that she could confirm with her instructing solicitors that no further evidence has been filed.

4. Having spoken to her instructing solicitors Ms Aziz applied for an adjournment. She submitted the solicitor with conduct of this matter has recently left the firm. That solicitor had considered whether further expert evidence is required to address the appellant's current medication and its availability in Zimbabwe. It appears the case worker now dealing with the matter was unaware that further expert evidence was being considered, and no further steps have been taken in that regard. Ms Aziz submits the appellant would be disadvantaged in having to proceed without that updating evidence. Mr Lawson accepts it is important to have up-to-date evidence, but the respondent is ready to proceed with the hearing listed before me.

5. I refused the application for an adjournment. I have already set out the history of this appeal noting in particular that the underlying decision of the respondent that is the subject of the appeal, is dated 6 February 2020. The issues before me are abundantly clear from my previous error of law decision. Notice of the hearing listed before me was sent to the parties on 5th April 2023 and the appellant's representatives have had ample opportunity to ensure any further evidence that is to be relied upon, is before the Tribunal. Whilst the appellant and his representatives might have considered securing further expert evidence, Ms Aziz was unable to confirm that an expert has indeed been instructed, and the delay for the provision of any report. The appellant is represented and the parties must

help the Tribunal to further the overriding objective. The overriding objective is to enable the Tribunal to deal with cases fairly and justly. The appellant has been represented throughout and has been able to participate fully in the proceedings. An adjournment would only serve to add unnecessary delay that is in all the circumstances unwarranted. I permitted the appellant to give oral evidence so that he can update the Tribunal as to the medication he is currently prescribed.

The hearing and the evidence before the Tribunal

6. The appellant relies upon the evidence that was previously before the First-tier Tribunal. That is:

    a. An appellant's bundle comprising of 78 pages.

    b. An appellant's supplementary bundle comprising of 135 pages.

    c. A letter from Dr Rebecca Hardy, Consultant Nephrologist, dated 9th February 2022

    d. The appellant's skeleton argument dated 20 August 2021.

7. The respondent relies upon the respondent's bundle that was before the First-tier Tribunal. In addition, Mr Lawson provided me with a copy of the respondent's CPIN; "Zimbabwe: Medical treatment and healthcare, version 2.0, April 2021."

8. The appellant attended the hearing and gave evidence. He adopted the witness statement that is at page 13 of the appellant's bundle and confirmed the content is true and correct.

9. In summary, the appellant added that he is still prescribed the medications that are listed in the letter of Dr Rebecca Hardy dated February 2022. In addition, he is now also prescribed Ranitidine to protect his stomach lining. He confirmed that he will require medication for the rest of his life and he is required to take his medication three times daily. He said that if he misses a dose, he will become poorly within a few hours. The appellant believes that the medications that he requires are not available in Zimbabwe and that he does not have the financial means to secure the medication from abroad. The appellant said that he and his mother have made enquiries as to the medication available in Zimbabwe, including the availability of alternatives, but none is available. I referred the appellant to paragraph [31] of the decision of Tribunal Judge Young-Harry in which it is recorded that the appellant's mother's evidence was that she had travelled to Zimbabwe but she did not find out whether the appellant's antirejection medication is available in Zimbabwe. The appellant said that he understood his mother had made enquiries, but he accepts that she told the Tribunal previously that she had not enquired about the availability of antirejection medication. The appellant claims he would be unable to afford the medication he requires because he would be unable to work full-time because of the various health conditions he is diagnosed with. The appellant's evidence is that he requires blood tests every month and is assessed by specialists about every six weeks. He

understands that he will require ongoing assessment for the rest of his life to assess his kidney function.

10. In cross-examination the appellant accepted that he has undergone a successful transplant, but he has experienced some 'rejections'. Those treating him have altered his medications to deal with those 'rejections'. He confirmed he last had dialysis in May 2016 before his transplant and will have to take immune suppressants for the rest of his life. Asked why his family in the UK could not assist with the cost of securing medication in Zimbabwe until he is able to secure some employment, the appellant said that his mother and sister live in the UK and they could not afford to help him with the costs. He maintained that he has several illnesses that would prevent him working full-time. The appellant accepted he has secured some qualifications in the UK, but said that he has made enquiries about employment such as a forklift driver, but such employment is not available in Zimbabwe. He said that at the moment he is unable to work or receive benefits because he is a foreign national. He explained that his mother has not attended the hearing before me because she has been working nights to cover the costs and expenses related to his representation.

The parties submissions

11. On behalf of the respondent, Mr Lawson submits the issues before me are set out in my error of law decision and relate to the health of the appellant.

12. Mr Lawson refers to the decision of the Upper Tribunal in AM (Art 3; health cases) Zimbabwe [2022] UKUT 00131 (IAC). At paragraph [62], the Upper Tribunal made the following general observation about "health cases":

> "… 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."

13. Mr Lawson submits there is no such evidence relied upon by the appellant here. Apart from the evidence of the appellant, and the evidence of Professor Aguilar, there is no evidence that the medication taken by the appellant would not be available to the appellant in Zimbabwe or that it would be unaffordable. Mr Lawson submits Professor Agular may be a 'country expert' but he is not a 'medical expert' properly qualified to express an opinion as to the availability of treatment and medication for Kidney disease in Zimbabwe.

14. Mr Lawson refers to the respondent's CPIN; 'Zimbabwe: Medical treatment and healthcare, April 2021'. In particular, section 3.14, that refers to 'Kidney disease and dialysis'. The background material establishes that the Zimbabwean government scrapped renal dialysis fees for those without health insurance or aid at all government health institutions. Here, the appellant has had a successful transplant and on his own account, he has not required dialysis since May 2016.

15. Mr Lawson accepts the appellant has a serious medical condition that is likely to require the appellant to take immunosuppressant medicines for the rest of his life. However, the appellant has failed to establish, on the evidence, that he would face a real risk on account of the absence of appropriate treatment in Zimbabwe or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his state of health resulting in intense suffering, or to a significant reduction in life expectancy. He submits the appellant has family connections to Zimbabwe and certainly in the short term, there is no reason why the appellant would not receive support from his family, both in the UK and Zimbabwe, to secure the medications that he requires.

16. On behalf of the appellant, Ms Aziz submits there is a wealth of evidence before the Tribunal regarding the appellant's medical history as set out in his GP records and there is no doubt the appellant required dialysis in 2016. She submits I should accept the evidence of the appellant that he will not be able to receive the treatment that he requires, in Zimbabwe, as credible. She refers to the expert report of Professor Aguilar that is in the appellant's supplementary bundle. She accepts the copy in the bundle is incomplete in the sense that the bundle does not include the first page of the report, and paragraphs 1 and 2 *(and part of paragraph 3)* are not in the evidence before me. Be that as it may, she drew my attention to paragraphs [31] to [52] of the report in particular, in which Professor Aguilar addresses the healthcare available in Zimbabwe and sets out his opinions.

17. Ms Aziz also draws my attention to paragraph 1.2.4 of the CPIN which refers to an acute shortage of human resources for health care. She refers to Annex A of the CPIN which she submits, is a list of available medication that an individual can access in Zimbabwe. She submits the medication that the appellant is currently prescribed is not referred to as being available in Zimbabwe, and that supports the oral evidence of the appellant that the medication he requires will not be available to him. Ms Aziz accepts the most recent independent medical evidence before me regarding the appellant's health and his on-going treatment is the letter from Dr Rebecca Hardy dated 9th February 2022. The GP notes in the appellant's bundle, although extensive, pre-date that letter. She submits the evidence of the appellant that he regularly visits specialists for on-going assessment is credible. At one point Ms Aziz suggested the appellant would be at risk during any flight from the UK to Zimbabwe, but when I pressed her for the evidential basis for that submission, she submitted that the risk arises because the appellant would need to ensure he is able to take his prescribed medication during the journey and would need to ensure that he is able to continue taking his prescribed medication on arrival in Zimbabwe. Ms Aziz submits the evidence of the appellant that he would be unable to afford the cost medication in Zimbabwe is also credible, although she accepts there is no evidence before me as to the cost of the medication the appellant requires.

18. Ms Aziz submits that taking all the evidence that is before the Tribunal together, I should find that there would be very significant obstacles to the

appellant's integration into Zimbabwe because of his health. She invites me to find in any event that there are very compelling circumstances for the purposes of s117C(6) of the 2002 Act and/or the decision to refuse to revoke the deportation order and to refuse the appellant's human rights claim is contrary to Article 3 by reference to the test set out in AM (Zimbabwe) v SSHD [2020] UKSC EWCA Civ 64.

DECISION

Analysis of the evidence

19. In reaching my decision I have had regard to all the evidence before me, whether or not it is referred to. I have had the opportunity of hearing the appellant give evidence and seeing his evidence tested in cross-examination. I have also had the opportunity of reading through, in particular, the appellant's GP records, the letter from Dr Rebecca Hardy dated 9th February 2022 and the expert report of Professor Aguilar.

20. In considering the oral evidence, I have borne in mind the fact that events that occurred some time ago can impact on an individual's ability to recall exact circumstances. I also recognise that there may be a tendency by a witness to embellish evidence because although the core of the claim may be true, he/she believes that by embellishing their evidence, the claim becomes stronger. I also remind myself that if a Court or Tribunal concludes that a witness has lied about one matter, it does not follow that he/she has lied about everything. A witness may lie for many reasons, for example, out of shame, humiliation, misplaced loyalty, panic, fear, distress, confusion, and emotional pressure. I have also been careful not to find any part of the account relied upon, to be inherently incredible, because of our own views on what is or is not plausible.

21. In summary, the appellant arrived in the UK in October 2002 when he was 13 years old with leave to enter for 6 months. He was granted further leave to remain until 23rd April 2012, and has remained in the UK without any lawful leave since that date. The appellant is now 33 years old.

22. The appellant has a criminal history but the index offences leading to the respondent's decision to sign a deportation order are the convictions in 2015 and 2017. The appellant was convicted of possession with intent to supply Class A drugs, on 6th March 2015 and sentenced to 2 years and 6 months in prison. On 21st December 2017, the appellant was again convicted of possession of a controlled drug (Class A), with intent to supply, for which he received a sentence of 54 months, to run concurrently with a sentence of 12 months, for obstructing a police officer.

23. I do not need to set out the background history in any further detail. Much of it is reflected in the preserved findings that are set out in paragraph [12] of my error of law decision:

    a. The 2015 sentencing judge took account took account of the appellant's learning difficulties, as it may have played a part in his decision making.

However, the 2017 offence amounts to an escalation in his offending, given it was a second more serious drug related offence. (paragraph 17 of the decision of FtT Judge Young-Harry)

b. The appellant is a foreign criminal. The length of his sentence, which exceeds four years, is indicative of the severity of the offence, and accordingly the public interest is significantly enhanced. (paragraph 18 of the decision of FtT Judge Young-Harry)

c. Although the appellant has spent more than half of his life in the UK, appellant has not had lawful leave in the UK since 2012. Accordingly the appellant has not been lawfully resident in the UK for most of his life for the purposes of s117C(4)(a) of the 2002 Act. (paragraph 19 of the decision of FtT Judge Young-Harry)

d. The appellant is socially and culturally integrated in the UK for the purposes of s117C(4)(b) of the 2002 Act. (paragraph 21 of the decision of FtT Judge Young-Harry)

e. Although the appellant has been away from Zimbabwe since he was 13, it is likely the appellant was brought up with some knowledge of his culture and traditions because of his mother. The appellant and his mother retain links to Zimbabwe as the appellant's grandparents along with an uncle and an aunt, live there. The appellant's mother remains in contact with her parents and siblings. Her parents are in their 80's and live in the village. They have a family home, and the appellant's mother visited recently. (paragraph 24 of the decision of FtT Judge Young-Harry)

f. The appellant will be enough of an insider to adapt to life in Zimbabwe, with the help of his extended family. He will have the capacity to participate in life there and before long, have an understanding of how society works; he will be able to operate day to day with the assistance of his family. The appellant will in time, also learn the language, given he will be familiar with it considering he lived there for 13 years as a child, then into his teenage years. (paragraph 25 of the decision of FtT Judge Young-Harry)

g. Although the appellant has not been in Zimbabwe since his childhood, and is likely to face some obstacles to his integration on return, including adapting to an unfamiliar culture and social norms, they do not reach the threshold of very significant obstacles. The impact will be reduced by the fact that the appellant's mother clearly still retains links to their home country, and it is likely the appellant has some cultural awareness. (paragraph 32 of the decision of FtT Judge Young-Harry)

h. The social economic difficulties which currently exist in Zimbabwe, do not reach the threshold of very significant obstacles. The appellant has acquired various skills and abilities in the UK, which will stand him in good stead on return. Although he claims he is not familiar with Zimbabwe, he will in time become reacquainted with Zimbabwe. Just as the appellant integrated into UK society over time, he will, within a reasonable time, integrate into the country of his birth. (paragraph 33 of the decision of FtT Judge Young-Harry)

i. If the appellant's transplant is not successful, dialysis is available in Zimbabwe, thus the prognosis will be much the same in Zimbabwe as it would be if he remained in the UK on dialysis. Without dialysis however,

the appellant would die. (paragraph 26 of the decision of FtT Judge Young-Harry).

j. The various courses the appellant has completed, may assist him in securing employment on his return to Zimbabwe. In the event the appellant is unable to work due to his health, his family both in Zimbabwe and in the UK, can assist him financially, until he is able to be independent. The appellant can maintain close links with his mother and sister in the UK. Similarly, the appellant can attend a similar church on return to Zimbabwe and be as actively involved as he is in the UK. (paragraph 35 of the decision of FtT Judge Young-Harry).

k. The conclusion of Professor Aguilar that it will not be easy for the appellant to integrate in Zimbabwe, in particular, because he does not have any family there, and he would not be able to operate on a day-to-day basis, is tainted by the finding of the Tribunal that the appellant does have a family network in Zimbabwe, whose presence will aid the appellant's reintegration. The relationships can be mended given their grandson would need their assistance, and particularly in light of his health condition. They would not turn him away, despite their disappointment in him. (paragraph 36 of the decision of FtT Judge Young-Harry).

24. It is unfortunate that the appellant and his representatives have failed to address their mind to the issues that arise in this appeal and the evidence required to support the claims made by the appellant. There is no comprehensive medical report from a treating clinician setting out a summary of the appellant's clinical medical history, treatment received over the years and any ongoing treatment or assessments he is likely to require.

25. The medical records in the appellant's supplementary bundle do not appear to be complete but from my review of the medical records, it is clear that the appellant has a history of cysteine stones and impaired renal function, which resulted in his presentation at A&E on a number of occasions. He was subsequently diagnosed with renal failure and considered for renal transplant. He had end stage renal failure secondary to cysteine nephropathy and benefited from a kidney transplant on 19th August 2016.

26. The appellant remained under the care of the renal transplant clinic at the University Hospitals of Leicester, where attended the clinic on several occasions where his health and medication were monitored. It is however right to say that there are a number of occasions upon which the appellant is recorded as having failed to attend appointments. On 10th April 2017, a letter was sent by the Renal Transplant Clinic to the appellant's GP referring to the appellant's failure to attend a follow-up clinic appointment *(for the fourth time)*, and highlighting the importance of the appellant attending the clinic so that his transplant kidney function can be monitored and any adjustment made to his medication so that he does not lose his kidney. When the appellant was reviewed at the Lincoln County Hospital on 22nd May 2017, the appellant is reported to have had an uneventful first six-month post-transplant with no evidence of rejection and good kidney function.

27. As Mr Lawson submits, the letter of Dr Rebecca Hardy dated 9th February 2022 is the most recent independent evidence regarding the health of the appellant and the treatment he is receiving. Dr Hardy notes the appellant had reported feeling better after a change in his medication from Mycophenolate to Myfortic. She recommended the appellant be prescribed Rampril 2.5mg daily and states that she planned for the appellant to be reviewed again through the transplant clinic in around 3 months. The medication prescribed is listed in the letter.

28. Although it is not confirmed by the appellant's GP or by any up-to-date medical report, I accept the appellant's evidence that he remains on the medication that is listed in the letter from Dr Rebecca Hardy. I also accept his evidence that he is now also prescribed Ranitidine. I accept that the appellant will need to take immunosuppressant medicines for the rest of his life to prevent his body's immune system from attacking the new kidney. I accept the immunosuppressant medicines are likely to weaken the appellant's immune system and make him more vulnerable to infections and he will need to take extra precautions against infection. I accept that he is likely to require some ongoing assessment, but in the absence of any evidence to support his claim, I do not accept that he requires blood tests every month or that he attends specialist appointments every six weeks. It has now been several years since the appellant received a kidney transplant and although I accept that in the past, his medication may have needed to be adjusted to avoid the risk of rejection, there is no credible evidence before me of any on-going complications that require attendance at clinics at the frequency claimed by the appellant. In the absence of any evidence whatsoever to support his claim, I also reject the appellant's account that he is unable to work because of his health. There is no evidence before me of any particular complications that prevent the appellant from undertaking meaningful employment on account of his health. It is obvious that even with kidney surgery, an individual should be able to return to work and normal activities. There is no evidence before me explaining why that is not possible for this appellant.

29. As to the appellant's reliance upon the report of Dr Agular regarding the treatment available in Zimbabwe, I note that Dr Aguilar is not a clinician directly involved in providing relevant health treatment and services with any expertise or knowledge of treatment options in the public and private sectors in Zimbabwe. He simply draws upon background material and reaches vague and broad conclusions that with respect, do not withstand scrutiny. I attach little weight to the opinions he expresses.

30. At paragraph 32 of his report Professor Aguilar refers to the respondent's CPIN. At paragraph [33] he refers to insufficient machines and staff to pursue a successful national policy on dialysis, where here, the appellant has undergone a kidney transplant and does not require dialysis. At paragraph [35], Professor Aguilar states it is difficult to anticipate the cost of "such treatment" and that he has tried in the past to secure details of the costs of "such treatments and medication" but clinics are not willing to outline costs without a medical examination of the patient. Professor

Aguilar fails to identify the "treatment" or "medication" that he is referring to and there is no evidence that he has made any enquiries regarding the particular medication required by the appellant. He has not considered, for example, whether the immunosuppressant drug Mycophenolate is available in Zimambwe and if it is not, what the cost of securing the drug might be from abroad. That is quite understandable because Professor Aguilar does not have the necessary clinical expertise and experience to be able to provide expert evidence in that respect. At paragraphs 36 to 38 of his report Professor Aguilar responds to the respondent's decision. At paragraph [37] he expresses the opinion that although renal facilities are available in Zimbabwe, there is no evidence that the appellant would have access to such renal treatment without his health deteriorating on two accounts. He refers to the pressure on equipment and staff in managing dialysis treatment and claims there is no evidence that the appellant would actually have timely access to such treatment. He fails to appreciate the appellant does not require dialysis treatment as matters stand. Second, he claims the appellant does not have family support in Zimbabwe, but that is not supported by the evidence before the Tribunal and findings made. Similarly, at paragraph 38, Professor Aguilar claims the appellant's illness would make him less able to secure employment in Zimbabwe, a country where unemployment is high and only the fittest and those who have family connections, secure jobs. The appellant does have family connections to Zimbabwe.

31. Professor Aguilar refers to background material that refers to the difficulties in the provision of healthcare in Zimbabwe, and at paragraphs 46, 47 and 50, he expresses the opinion that the therapies and medication available in the UK are not available in Zimbabwe. I attach little weight to that opinion when as Professor Aguilar himself acknowledges, at paragraph 38, he has not seen a medical report relating to this appellant. He cannot in the circumstances provide an expert opinion as to the availability of the "therapies and medication" required by the appellant. He does not know what they are, and if the precise medication prescribed at the moment is not available, Professor Aguilar cannot possibly offer an expert opinion as to any alternatives that might be available. Professor Aguilar claims at paragraph 48 that it is most likely that any interruption or delay in the appellant's medical treatment would endanger his life as he suffers from a serious medical condition. Professor Aguilar has neither the professional qualifications nor relevant experience to provide such an opinion. I also attach little weight to the opinion expressed at paragraph [50] that the appellant will not be able to get the necessary funds to acquire the medications he needs. First, Professor Aguilar himself acknowledges that he does not know what the cost of the medicine will be, and second, the appellant does have family support that he can turn to. Even if the appellant has to pay for some assessment and for medication, I find that he has the ability to turn to the support of his mother and sister in the UK, who financially support him at the moment. I find they would undoubtedly continue to support him on his return to Zimbabwe whilst he finds employment.

32. I also reject the submission made by Ms Aziz which at one stage appeared to go so far as to say that medications that are not listed in Annex A of the CPIN, are not available in Zimbabwe. Annex A of the CPIN records the list of available medication according to 'Medical Country of Origin Information (MedCOI)', and is based upon short extracts from larger reports or responses to specific questions. The fact that a specific question has not been asked about the availability of a particular drug to establish whether or not it is available, is not to say that the drug is not available.

Article 8

33. Having made those findings I now turn to the three issues that I identified in my error of law decision that have been the focus of the hearing before me.

34. I have considered whether there would be very significant obstacles to the appellant's integration into Zimbabwe because of his health. In SSHD -v- Kamara [2016] EWCA Civ 813, Sales LJ said, at [14]

> "In my view, the concept of a foreign criminal's "integration" into the country to which it is proposed that he be deported, as set out in section 117C(4)(c) and paragraph 399A, is a broad one. It is not confined to the mere ability to find a job or to sustain life while living in the other country. It is not appropriate to treat the statutory language as subject to some gloss and it will usually be sufficient for a court or tribunal simply to direct itself in the terms that Parliament has chosen to use. The idea of "integration" calls for a broad evaluative judgment to be made as to whether the individual will be enough of an insider in terms of understanding how life in the society in that other country is carried on and a capacity to participate in it, so as to have a reasonable opportunity to be accepted there, to be able to operate on a day-to-day basis in that society and to build up within a reasonable time a variety of human relationships to give substance to the individual's private or family life."

35. Although I accept the appellant will continue to require monitoring and medication for the rest of his life, I am not satisfied that the medication and long-term care required by the appellant would not be available to him in Zimbabwe. The appellant had a kidney transplant in 2016 and it appears that he is now on a settled regime of prescription medication. Paragraph 3.14.2 of the CPIN that I have been referred to states:

> "A MedCOI response to an information request, dated 16 June 2020, about kidney disease, liver disease, HIV/AIDS and hypertension, stated that kidney specialists, who can treat people with kidney diseases, were available in the Harare Central Hospital (public facility). Kidney function tests for creatinin, ureum, proteinuria, sodium and potassium levels could be carried out at the Harare Central Hospital. Haemodialysis could be also carried out at the Harare Central Hospital. Kidney transplants could not be carried out at the Harare Central Hospital".

36. There will inevitably be some disruption for the appellant to begin with, but there are clearly specialists in Zimbabwe who can treat people with

kidney diseases and I am satisfied that any on-going kidney function tests required by the appellant will be available to him. He will undoubtedly return to Zimbabwe with a sufficient supply of medication from his prescriptions in the UK. On his account, the appellant is now managing his health and knows what he must do to secure the help that he requires. He has clearly gained an insight into the importance of his medication and the steps he must take to avoid infection. I find he will adjust to life in Zimbabwe within a reasonable timescale. I find the appellant would be able, within a reasonable period, to find his feet and exist and have a meaningful life within Zimbabwe securing the medication he requires. Taken together with the preserved findings that I have set out at paragraph 23 (g) to (k) above, I find that the medical evidence before the Tribunal taken together with the background material relied upon by the parties does not establish that there would be very significant obstacles to the appellant's integration into Zimbabwe because of his health.

37. The appellant therefore fails to meet the statutory exceptions to deportation and what he must show, if he is to avoid deportation on Article 8 ECHR grounds, is that there are very compelling circumstances, over and above those in the exceptions to deportation, which suffice to outweigh the public interest in deportation: s117C(6) of the 2002 Act.

38. It is useful to note that in relation to s117C (6) of the 2002 Act, the court gave guidance in NA (Pakistan) v Secretary of State for the Home Department [2016] EWCA Civ 662. The following is relevant:-

> "29. In our view, the reasoning of the Court of Appeal in JZ (Zambia) applies to those provisions. The phrase used in section 117C(6), in para. 398 of the 2014 rules and which we have held is to be read into section 117C(3) does not mean that a foreign criminal facing deportation is altogether disentitled from seeking to rely on matters falling within the scope of the circumstances described in Exceptions 1 and 2 when seeking to contend that 'there are very compelling circumstances, over and above those described in Exceptions 1 and 2'. As we have indicated above, a foreign criminal is entitled to rely upon such matters, but he would need to be able to point to features of his case of a kind mentioned in Exceptions 1 and 2 (and in paras. 399 or 399A of the 2014 rules), or features falling outside the circumstances described in those Exceptions and those paragraphs, which made his claim based on Article 8 especially strong.
>
> 30. In the case of a serious offender who could point to circumstances in his own case which could be said to correspond to the circumstances described in Exceptions 1 and 2, but where he could only just succeed in such an argument, it would not be possible to describe his situation as involving very compelling circumstances, over and above those described in Exceptions 1 and 2. One might describe that as a bare case of the kind described in Exceptions 1 or 2. On the other hand, if he could point to factors identified in the descriptions of Exceptions 1 and 2 of an especially compelling kind in support of an Article 8 claim, going well beyond what would be necessary to make out a bare case of the kind described in Exceptions 1 and 2, they could in principle constitute 'very compelling circumstances, over and above those described in Exceptions 1 and 2', whether taken by themselves or in conjunction with other factors relevant to application of Article 8."

39. The test in s117C(6) is therefore a proportionality test, balancing the rights of the appellant against the public interest in his deportation. The scales are nevertheless weighted heavily in favour of deportation. The appellant has been sentenced to a period of imprisonment of four years and there is a cogent and strong public interest in his deportation. For reasons I do not repeat, I am satisfied the appellant will be able to access treatment and medication in Zimbabwe. Although my focus has been upon 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 Zimbabwe would be equivalent or inferior to that provided in the healthcare system in the UK.

40. Looking at all the evidence before me in the round, in my final analysis, I find the appellant's protected rights, whether considered collectively with rights of others that he has formed associations with, or individually, are not in my judgement such as to outweigh the public interest in the appellant's removal having regard to the policy of the respondent as expressed in the immigration rules and the 2002 Act. I am satisfied that on the facts here, the decision to refuse to revoke the deportation order and to refuse the appellant's Article 8 claim is not disproportionate to the legitimate aim of immigration control. I am obliged therefore, to dismiss his appeal on Article 8 grounds.

Article 3

41. I turn to consider whether the removal of the appellant would be in breach of Article 3. In AM (Zimbabwe) v SSHD [2020] UKSC EWCA Civ 64, Lord Wilson noted the ECtHR set out requirements *(at paras 186 to 191)* for the procedure to be followed in relation to applications under Article 3 to resist return by reference to ill-health. It is for the appellant to adduce evidence capable of demonstrating that there are substantial grounds for believing that, if removed, he would be exposed to a real risk of being subjected to treatment contrary to Article 3. The Supreme Court confirmed that that is a demanding threshold for an applicant. His or her evidence must be capable of demonstrating "substantial" grounds for believing that it is a "very exceptional case" because of a "real" risk of subjection to "inhuman" treatment.

42. Taking the appellant's claim at its highest, I am prepared to accept that the appellant discharged the burden of establishing that he is a seriously ill person, albeit on the evidence before me, I find the appellant's condition is currently well controlled and managed.

43. Ms Aziz accepts the burden of establishing that there is no appropriate and accessible treatment in Zimbabwe rests with the appellant. As I have already set out, there are clearly specialists in Zimbabwe who can treat people with kidney diseases and I am satisfied that any on-going kidney function tests required by the appellant will be available and accessible by him. There is unfortunately an absence of any credible evidence before me that the medication that is prescribed to the appellant (or a suitable alternative) is not available in Zimbabwe, or, if it is available, it is unlikely to be affordable. There is quite simply no evidence before me as to the

availability or costs of any immunosuppressant medication in Zimbabwe or the cost of importing it from abroad.

44. From his oral evidence before me, it is clear that the appellant is aware of the importance of his medication and I have no doubt he would take the medication required, whether that is as now prescribed, or a suitable alternative. He gave evidence recognising the importance of the medication and the consequences of failing to take it. I accept the appellant is likely to require monitoring for the rest of his life and although I do not accept he is monitored every six weeks as he claims, I am prepared to accept he is likely to require clinical assessment every three to six months. In her letter dated 9th February 2022, Dr Hardy indicated a review in around three months. The availability of on-going monitoring in Zimbabwe might be less frequent than that offered in the UK, but treatment will be available to the appellant when it is required. I am 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, I note that the appellant's condition has been controlled notwithstanding his failure to attend appointments on occasions in the UK.

45. I find the appellant will in the fulness of time be able to fall back on the qualifications he has secured from courses completed in the UK to generate an income in Zimbabwe and in any event, he will be able to turn to financial support in the short term from his mother and sister. His mother has supported him throughout and I have no doubt, she will do so going forward. The appellant's grandmother remains in Zimbabwe and in the short term, he may find himself 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 to the appellant. I therefore find treatment to avoid a breach of Article 3 ECHR is available and accessible in Zimbabwe.

46. In the end having carefully considered all the evidence before me, I am not satisfied that the appellant has established that there are substantial grounds for believing that he would face a real risk of being exposed to either a serious, rapid and irreversible decline in the state of his health resulting in intense suffering or the significant reduction in life expectancy as a result of either the absence of treatment or lack of access to such treatment.

47. It follows that the appeal cannot succeed on Article 3 grounds.

Notice of Decision

48. The appeal is dismissed on Article 3 and Article 8 grounds.

Case No: UI-2022-003252
First-tier Tribunal No: HU/02886/2020
V. Mandalia

Upper Tribunal Judge Mandalia

Judge of the Upper Tribunal
Immigration and Asylum Chamber

12 May 2023