IN THE UPPER TRIBUNAL
IMMIGRATION AND ASYLUM CHAMBER

Case No: UI-2023-004149

First-tier Tribunal No: PA/53763/2021
IA/10586/2021

THE IMMIGRATION ACTS

Decision & Reasons Issued:
On 18th June 2024

Before

DEPUTY UPPER TRIBUNAL JUDGE SAFFER

Between

SOLIU ADEKUNLE ALID
(no anonymity order made)

Appellant

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Miss Khan of Counsel
For the Respondent: Mr Thompson a Senior Home Office Presenting Officer

Heard at Phoenix House (Bradford) on 5 June 2024

DECISION AND REASONS

1. The Appellant was born on 4 May 1966. He is a citizen of Nigeria. He appealed against the decision of the Respondent dated 16 July 2021 refusing his protection and human rights claim. That appeal was dismissed by First-tier Tribunal Judge Caskie in a decision promulgated on 27 April 2023.

2. Permission to appeal was neither sought nor granted in relation to the dismissal of the appeal on asylum grounds which therefore stands. Consequently, given the principle of open justice, the anonymity direction previously in force no longer needs to apply. There is no challenge to the findings relating to private and family life with the exception of the ability to fund the medical treatment required.

3. When the appeal came before me on 30 November 2023, the Respondent conceded that the Judge had materially erred in failing to

properly consider the financial sources available to him to fund medical treatment should he be returned to Nigeria. I consequently found that there was a material error of law and having heard submissions set aside the decisions made in relation to Articles 3 and 8 and the findings in [44, 46, 47, and 48]. The rest of the findings remain. The issues remaining were the Article 3 "medical ground" appeal and the Article 8 private life claim which is based on whether his circumstances meet the very significant obstacle test to be met to reintegrate without undue hardship, and the impact on his ability to access medical treatment, and whether the facts could be sufficient to reach the high thresholds required to found a claim.

4. At the hearing on 30 November 2023, this being recorded in [11] of that decision, I directed that;

> "the Appellant shall file and serve such additional evidence as he intends to rely on the medical and financial aspects of the Article 3 and Article 8 private life appeal by 20 December 2023".

5. On 20 December 2023 the Appellant's Solicitor wrote seeking an extension to the timetable to file the evidence by 12 January 2024. They stated that they received the decision including the direction on Sunday 10 December 2023 by email from the Upper Tribunal. The Solicitor said he was unaware of the direction until the following day 11 December 2023. They stated that due to a small staff base and very significant caseload they have been unable to obtain the evidence required.

6. Upon receipt of that application I issued the following directions on 22 December 2023.

> "4. The application is disingenuous for 2 reasons. Firstly the Appellant was represented at the hearing on 22 November 2023 and it is very hard to believed that a Counsel as experienced and competent as Mr Schwenk would not have notified the Solicitor that day of the result of the hearing. There is no evidence from him to that effect, or apology for his tardiness if that is indeed what happened. Likewise it is very hard to believe that the Solicitor would not ask Mr Schwenk what had happened at the hearing. Secondly the extension application was not made until the day the evidence was required. That application did not reach me until my return from annual leave on the evening of 22 December 2023 when I returned to the United Kingdom, the last working day before the Christmas break.
> 5. Due to the poor behaviour of the Solicitor, in the interest of justice, however I feel compelled to grant the extension sought as nothing will be gained by refusing it."

7. The bundle was filed on 15 January 2024. No subsequent application has been made to file any additional evidence. No application has been made for any witness to give evidence by remote electronic means. Miss Khan, having taken instructions, said that the reason for the delay in the bundle being filed was due to problems getting evidence from the witnesses. That is a different reason to the one given in the application and adds to the disingenuous nature of how the Appellant's Solicitors have dealt with the additional evidence.

8. As requested by Miss Khan, given the Appellant's physical health, regular breaks were provided. I noted for myself how unsteady on his feet he

was. At one point he nearly fell. At another he had to lie down on seats outside the hearing room. With his consent the hearing continued while his witness, Linda Ngabu, gave evidence in his absence, the Appellant having completed his evidence. The safeguards to his interests were protected as Miss Khan was in the hearing room throughout, and the hearing was recorded. He was assisted by Tribunal staff when he returned to the hearing room. At times he sat and at times he stood due to his physical discomfort.

The First-tier Tribunal preserved findings

9. Judge Caskie made the following findings in relation to the issues before me that have not been set aside:

> "34. I noted that the Appellant indicated that he had both (sic) and uncle and nephew who have a long history of knowledge of the Appellant's difficulties who did not provide evidence before me, either orally or in writing. The Appellant indicated that each had provided financial support at different times for him and it is in my view inconceivable that (sic) they would what have been told by the Appellant why he could not simply return to Nigeria. The Appellant has evidence available to him from each of those individuals as to the explanation he provided to them when he was seeking financial support that would have shown consistency with the account he has now provided to me. I was asked rhetorically what else the Appellant could have done. It is clear he could have provided evidence to this Tribunal from sources which were and are available to him that he did not provide. His failure to do so undermines his credibility and reliability…
>
> 43. The Appellant clearly suffers from serious medical conditions, including chronic pain and physical injuries which have impacted significantly upon his mental health. He will clearly have difficulty, in light of the content of the expert report, in obtaining medical support for either his physical or mental health problems. However, it is not being suggested that there is a complete absence of relevant facilities available in Nigeria rather the suggestion made by Mr Greer was that the Appellant would not be able to access such facilities as are available because of his poor financial position..."

The lay evidence

10. In his statement (2 December 2021) the Appellant said he will not be able to reintegrate in Nigeria. He has nothing there. It has totally changed. He is totally integrated here. He is westernised. His mannerisms and behaviour are tailored to life here. He will not be able to sit on a plane for long as he will be in serious pain.

11. He added (25 January 2023) that he has no regular contact with anyone in Nigeria. He was last in contact with his wife in around 2009 or 2010. They had 3 children together. They do not contact him. He had not had contact with them for 2 or 3 years. He used to speak to his eldest daughter sometimes through a friend (Dauda) who arranged for them to call him when he was with them. He is still in contact with Dauda. They lived in the same village. He has his own family and would not be in a position to provide the Appellant with any support.

12. He sometimes communicates with his oldest son (Ridwan) who is deaf using WhatsApp. He was born in 1993. He lives in a school that has

a department to teach disabled children and is cared for by the proprietor of the school with whom he is in contact.

13. The Appellant's older brother died in about 2000. He had 3 daughters and a son. Two of his daughters are married. He last had contact with the eldest one in about 2010 or 2011.

14. His older sister left Nigeria 10 years ago having suffered a stroke and went to the USA for medical treatment. She has a son living here who rang to say he was here with his family. The Appellant does not know where he is living.

15. His uncle (Amoussa Ajani) lives in Birmingham with his family and worked as a taxi driver. He has 4 children and would not be in a position to provide any support in Nigeria.

16. The only person who supported him before he left Nigeria was his nephew who has moved to the USA.

17. He has a niece who is married and lives in Lagos. He has not had any contact with her since shortly after he arrived here.

18. He last had contact with the friend who arranges for him to speak to his family on WhatsApp, in the summer of 2022. He has no contact with anyone else in Nigeria.

19. He has been with Ms Ngabu since 2017 or 2018. She is disabled with a spinal cord problem. He spends a lot of time at her house and she helps to look after him. She helps both physically and with his mental health and tries to help him from being too depressed.

20. Since he suffered further injuries when he fell over here (in icy conditions in November or December 2008 - see Judge Caskie decision [35], the original injuries being due to a motor bike accident while living in Nigeria in 2004 - skeleton argument [3]), he has very significant pain and is unable to sit for any time without the pain being too intense. He sees doctors regularly. He is prescribed Codeine 15mg, Pregabalin 300, Contiflo 400, Sertraline 100mg, Naproxen 250mg x3, Lansoprazole 300mg and Colecalciferol 899IU. He has treatment for pain management. He has spinal block injections that provide some relief when the pain is particularly bad. He is constantly in pain and finds it difficult to concentrate on what is happening.

21. In Nigeria he would have nowhere to live and no way of supporting himself. He does not believe he could get a job with his disabilities. He would not be able to access the medical care he needs. He has no one in Nigeria who could provide support.

22. He added (8 January 2024) that he had some support from his nephew in early 2005 for a few months when he was in Lagos. He moved to the USA in 2006 or 2007 where he is still living. He believes he is not working and so would not be able to support him. He is married with

children and looks after his mother after she had her stroke. He speaks to him about once a month when he speaks to his sister. He is in contact with her other son (Taiwo Talbi) who lives in London but is not able to assist as he is married with 5 children to care for.

23. The information he provided about contact with his family and other people in Nigeria has not changed. He only has contact with Dauda who is from his village in Saki (also spelt Shaki in the papers) who has his own family and cannot provide support.

24. He has no contact with his brother's children.

25. Mr Ajani (his uncle) lives in Birmingham with his 4 children, and works as a taxi driver. He cannot provide him with support in Nigeria. They speak every few weeks but he has not seen him since, he thinks, 2016. It is a long time since he gave support.

26. He stays with Ms Ngabu quite a lot due to problems with the house provided by the Respondent. He remains on the same medication except that he is now on Codeine 30mg and takes folic acid. He is waiting for an appointment at the pain clinic. He still has spinal block injections that provide some relief when the pain is really bad.

27. In oral evidence he added that his health has deteriorated. He is on new medication for dizziness. It started more than a month ago. He has been to see his GP twice. He has had blood taken twice. He uses a blood pressure monitor. He has been told his blood pressure is OK.

28. Sometimes Ms Ngabu gives him £10. She would not sponsor him to come here.

29. He is in contact with Mr Ajani. He cannot help as he is struggling to cope with his family.

30. He was last in contact with Ridwan maybe a week or 2 ago. He has no idea if he works. He does not think so. He is not sure what he is doing. He is retaking some course part time as he missed some results. They do not discuss if he has ever worked. He has advised him to get a job and wants him to do something with the local council. The problem is his results. He does not pay rent.

31. Even if relatives in the United Kingdom and USA could support him, he would be unable to live with Duada as he has 3 wives and 9 children. He has not asked him as it is not possible.

32. He last spoke with his daughter maybe 4 or 5 years ago. She is 21. He does not know if she is working. She may be learning.

33. Mr Ajani is in Birmingham. He is not at the hearing as he is struggling. He had a kidney transplant. He does not know why there was no application for him to give evidence by video link. He did not ask him.

Mr Talbi (his nephew) is in London. He said he could not come. He did not know he could give evidence by video link.

34. He was last in touch with his sister and nephew who live in the USA 3 weeks or a month ago. He did not ask for letters if they could support him as he did not know it was necessary. She cannot support him as she had a stroke which affected her leg and hand which is why she went to the USA. His nephew has a wife and child and a lot of people to support.

35. Before he came to the United Kingdom he lived in Lagos. His home town is Saki which is 5 hours' drive from Lagos.

36. Linda Ngabu wrote (undated letter) that since they met in 2017 and been in a relationship the Appellant has suffered constant severe pain and a lot of physical and mental health issues. He suffered significant injuries to his private parts some years ago which makes it very difficult for him to carry out daily activities. He cannot sit, stand, or walk without suffering significant pain, so all movement is very challenging. He finds it very difficult to sleep at night because of the pain he suffers. Sometimes he gets very upset and finds the pain difficult to deal with. This can cause him to shed tears. She is aware that he has a history of self-harm and has previously taken overdoses of some of his medication. She helps with cooking and domestic chores when she is fit to do so. He tries to do most of his own domestic work when he is well enough but often finds it too difficult. They support each other.

37. She added (10 January 2024) that she receives Universal Credit and additional payments as she is unable to work. Her disposable income after she pays her rent is £758.80. She listed her monthly costs of utilities and council tax, phone TV and broadband, washing machine rental, and transport which total approximately £400. She buys food and other essentials from the remainder. She only buys clothes when she has to. She has no savings or other assets. She cannot help the Appellant financially in Nigeria. She does not think he would survive for any length of time without the support he has here. In the last few months his memory has got worse. It would be impossible for him to look after himself if he was alone in Nigeria. As far as she is aware Mr Ajani and Mr Talbi have not helped him or sent him anything or tried to support him financially.

38. In oral evidence she added that she sees the Appellant maybe 3 or 4 times a week. He leaves the house when he feels OK. When he is at home he is by himself. When she is sick he cooks for her and does some dusting in the house. She bulk cooks and freezes meals and he takes them with him. She is in contact with Ridwan. She has not asked him if he works. She has had no contact with Mr Ajani or Mr Talbi. She sometimes gives him £10. She could not sponsor him from Nigeria. When speaking to Ridwan it is sometimes through video calls and they use signs (I noted that when she was explaining how they communicated she was using her hands in a version of sign language). The Appellant cooks

fish in the oven for her but not often. Sometimes he puts porridge or noodles in the microwave. Someone from the Church does her shopping.

39. It states in an unsigned and undated letter from Mr Ajani that he has resided in the United Kingdom since 2007 and has indefinite leave to remain. He cannot support the Appellant financially. His wife and 4 children are dependent on him. He is a taxi driver. He has no other income or assets. He provided the Appellant with accommodation and limited financial support when he first arrived.

40. It states in an unsigned letter from Mr Talabi (10 January 2024) that he supported the Appellant in Nigeria from 2005 to 2008. He is married with 4 children. He is a dependent migrant. He is yet to stabilise as he came to the United Kingdom barely a year ago. He cannot provide any financial support to the Appellant here or in Nigeria.

41. Dr Sariat Adelakun wrote (28 December 2021) that Ridwan has been at the Salamat Olaniyan Memorial Model College since 2010, is deaf, and is in their care.

42. Correspondence identified the Appellant's housing situation in 2020, ongoing pain management, problems accessing his accommodation and using steps due to the pain, attendance at hospital for an ultrasound and assessment of hepatitis B, and medication prescriptions. Ms Ngabu's Universal Credit entitlement letter identified a total monthly payment of £,1099 made up of £368.74 standard allowance, £440.86 for housing, and £390.06 for limited capability for work and related activity.

Medical evidence

43. Dr Bradley, GP, wrote (5 April 2019) that;

> "Mr Adil continued to suffer from chronic pain. This has been attributed to chronic prostatitis which resulted from a penetrating injury to the perineum following a road traffic accident… sometimes he is incapacitated entirely by his pain… He has also had difficulties with his mental health…(he has) hepatitis B…Mr Adil's pain was such that he took a dangerous overdose of his painkilling medication…
> It is likely that leaving the UK would worsen Mr Alid's mood further which could prove hazardous to Mr Adil should this precipitate a crisis in his mental health…
> I believe he would find the experience of a long flight very difficult…I am unsure if he could cope with remaining seated due to the pain this would cause him."

44. Dr Bradley wrote (15 July 2019) that the Appellant continues to be troubled with chronic pain and has continued to struggle with his mental health. He has said he worries about self-harming due to the pain and it has been noted he has thoughts of suicide due to his immigration status. He has collapsed and attended accident and emergency. Dr Bradley reported in response to specific questions;

> a) I would consider that Mr Alid is unable to leave the UK as his mental health is a concern and he has suggested he could harm himself. I would expect his mental health to deteriorate should he be removed from the UK. He is also unsuitable for removal from the UK as he has further investigations ongoing for his episodes of

collapse, for which we currently have no diagnosis. Mr Alid also requires careful management of his pain medication and support for his chronic pain. Should the management of his chronic pain deteriorate I would expect his mental health to worsen also.

b) The main risks of removal from the UK, would in my view be, deterioration in mental health and possible self-harm or suicide. I would also expect removal from the UK to result in a great difficulty for Mr Alid in coping with his chronic pain, which would lead to an intolerable quality of life for him."

45. Dr Bradley added (13 December 2021) that his situation is largely unchanged since letter of 27 January 2021 and 9 October 2020 (that were not included in the bundle for me). He continues to suffer from intractable perineal pain. He has had depression which is part related to his chronic pain and challenges with his social situation. In the absence of primary and secondary care medical services his health could deteriorate. It is likely his depression symptoms could worsen. His health could also be at risk were he not to have access to further monitoring of his pancytopenia and hepatitis B. (I note here that I am aware that pancytopenia relates to having too few red and white blood cells and platelets.)

46. Nick Edwards, Psychiatric Nurse and Therapist at Solace, noted (14 July 2020) the Appellant's history of low mood, depression, suicidal ideation, self-harming through burns, an overdose of sleeping tablets, dizzy spells and blackouts, and symptoms of Post Traumatic Stress Disorder. He would benefit from Eye Movement Desensitization and Reprocessing at some point. He also noted (undated) that he had worked with the Appellant since May 2020. Initially he was not provided with the food he needed in the hotel he was placed in to take his pain killing medication. He could not get to the dining room due to his mobility problems and had to make do with a few sandwiches. The stairs in the flat he was moved to exacerbated his perineal pain. Having to clean before using the kitchen, bathroom and toilet was too much for him.

47. I note from the skeleton argument filed on behalf of the Appellant (4 February 2023) that it adds at [10] in addition to the above the Appellant has haemorrhoids, takes Vitamin D supplements, and has medication used to treat an enlarged prostate. The skeleton argument noted at [22];

> "Codeine is not available in Nigeria, having been banned in 2018. The other drugs" the Appellant is prescribed "are available from online pharmacies in Nigeria and cost around NGN 854.41 per day (the equivalent of £1.54 per day)."

Country evidence

48. I will not summarise the articles and reports submitted by the Appellant as it has not been suggested that they add to the evidence contained in Professor Dr Jaqueline Knoll's report or the Respondent's country information note: medical treatment and healthcare, Nigeria, December 2021. It is unnecessary to set all the evidence out in detail or their sources of information as the issues are not the availability of

treatment, but its accessibility, and the reports accord with each other. The key sections in Professor Dr Knoll's report are;

> "[5] Nigeria's health care system is poorly equipped and characterized by weak infrastructures, inadequate funding, and poor policy-making and implementation ... Nigerians suffer from high levels of infectious diseases ... However, the only persons that may access adequate, high-quality treatment and medication are those who are affluent enough to afford private doctors and health care facilities... The large majority of Nigerians do not have the necessary means to access adequate health care…
> [6] Only a very small percentage … of the Nigerian population are health-insured and private expenditure on health account for almost 75 percent of total health expenditure, of which about 70 percent is spent as out-of-pocket expenditure for access to health services in both government and private facilities. Payments of health services and medication involve extremely high expenditures for individuals and private households which most people cannot afford, less so where chronic diseases are concerned ...
> [7]... there are fewer health workers per unit population than required to provide effective health services to the entire Nigerian nation. As well as that, Nigeria is suffering from the so-called brain-drain of medical doctors and other health professionals to richer countries ...
> [9] Hence, public health services in Nigeria are of poor quality and not adequately available, accessible, and affordable to the large majority of people in need of them. While many private health services are of better quality, they are even less accessible and affordable for the vast majority of Nigerians ... The lack of healthcare also results in a very low life expectancy in Nigeria. Life expectancy at birth was 54,7 in 2019 (UNDP 2020)...
> [10] ... in Nigeria the elderly and sick depend and rely on kin and informal social networks for support and care... Where an older and sick and/or physically frail person is not a member of kin and social networks, s/he will most likely become a victim of social destitution and will in most cases have a severely reduced life expectancy...
> [11] ... Old and sick people without kin ties and no personal network of support have a very poor quality of life in Nigeria…
> [14] In Nigeria… mental health is not perceived a priority…
> [16] Professional mental healthcare is very scarce in Nigeria…
> [19] …Given the lack of mental healthcare services, caring for people with mental problems is mostly left to family members…
> [26] People suffering from psychological and mental disorder are heavily stigmatized…
> [27] The mentally ill are often expelled from their communities or left in the streets to beg to make a (miserable) living. Given that mental illness is associated with personal failures, the mentally ill are perceived as a source of shame by their families who will therefore often keep them locked away in their homes or drop them off at some facility considered being in charge of looking after people with mental health issues…
> [32] The investigation concerning Nigerian facilities in charge of providing mental healthcare that Human Rights Watch conducted between 2018 and 2019 …brought to light that "*Thousands of people with mental health conditions across Nigeria are chained and locked up in various facilities where they face terrible abuse. Detention, chaining, and violent treatment are pervasive in many settings, including state hospitals, rehabilitation centers, traditional healing centers, and both Christian and Islamic faith-based facilities*".
> [33] Such abuse is not an anomaly, it is the rule rather than the exception…
> [37] Sanitary conditions at mental health facilities are horrific in most cases…
> [38] It is not uncommon for people in mental healthcare facilities to be deprived of food and water…
> [42] … he would also face a risk of being branded a witch and therefore of falling victim to abusive practices and to further social isolation and ostracism…

> [44] … unemployment rates are very high in Nigeria … In reality, less than forty percent of Nigerians are fully employed, with unemployment affecting young people and women most severely… Most employment is secured through social and ethnic networks in Nigeria…
> [45] …older and sick adults…who are without substantial financial resources and not part of extended family and social networks, will most likely become socially destitute and homeless…
> [47] … Social destitution would involve homelessness, the lack of adequate food and sanitation, neglect, social isolation and stigmatization, and – consequentially – deteriorating health, and, not unlikely, Mr Alid's premature death…"

49. Professor Dr Knoll added (undated letter) that she has considered her assessments in light of the current circumstances. There is no change in her opinion.

50. The Respondent's country information note gives further detail on the limited, but not-non existent, mental health care services and noted that;

> [2.5.1] …people purchase drugs from both public and private medicine stores. In rural areas, 'patent medicine stores', which are usually unregulated/ unsupervised, are the most frequent kind of private drugs store.
>
> [2.5.2] …the current system of drugs' distribution in Nigeria is chaotic. 'The most notable fallout of the chaotic and unorganized drug distribution system is the unrestricted circulation of fake, substandard, and adulterated pharmaceutical products.' …between 15% to 75% of total drugs circulating in the country are fake… poor coordination of medicines procurement and supply to public facilities leads to a shortage of medicines, which are very common in governmental hospitals particularly in primary healthcare facilities.
>
> [2.5.4] …The high cost of accessing government specialist hospitals as well as teaching hospitals and the bureaucratic structure of general hospitals has increased the demand for private health provision, which predominantly caters for the middle-class cadre. Because of the availability of genuine drugs and the services rendered by private practitioners, the costs are generally high and are, thus, not easily accessible to the masses. Although the licensed pharmacist on the other hand sells genuine drugs, there are instances where some have engaged in sharp practices by mixing genuine and fake drugs…
>
> [2.6.9] …There are general practitioners, internists, physical therapists, psychologists… in most tertiary centres…
>
> [15.1.1] The Society for Gastroenterology and Hepatology In Nigeria … is a national association of medical professionals involved in the diagnosis, treatment and prevention of diseases of the Gastrointestinal Tract (GIT) and the Liver… SOGHIN members are present in all Federal teaching hospital[s], many Federal Medical centers, State teaching and general hospitals and private hospitals from every region of Nigeria… There are over 300 Members including specialists like Gastroenterologists, Hepatologists, Haematologists…'
>
> [15.1.2] … outpatient and inpatient treatment by heptologists is available in Nigeria.

Respondent's submissions

51. The Respondent asserted (16 July 2021) that the Appellant is in contact with family in Nigeria and has an adult support network that could aid his reintegration. He has resided here for (now) 15 ½ years. He

will be familiar with the culture and language of Nigeria having lived there for most of his life. He arrived here when he was 42 ½. He could maintain contact with friends through modern means of communication. He has demonstrated extreme fortitude in travelling here and establishing support. He is resourceful and would be able to reestablish his life in Nigeria. There are no very significant obstacles that would hinder his reintegration in Nigeria or exceptional circumstances.

52. In Nigeria, treatment and medication is available and accessible for hepatitis B and mental illness including counselling. There are no substantial grounds for believing he faces a real risk of being exposed to a serious, rapid and irreversible decline in his health resulting in intense suffering, or a significant reduction in life expectancy upon his return to Nigeria. Family support is available in Nigeria to reduce the risk of self-harm.

53. Mr Thompson submitted orally that the high threshold to succeed in an Article 3 "medical" appeal had not been met. There was a lack of up to date medical evidence. The Respondent's December 2021 CPIN is still relevant. The issue is access to treatment. As a Nigerian national he has equal opportunities to access medical services. The letters from witnesses in the United Kingdom carry little weight as they have not attended the hearing. There is no evidence from family in the USA regarding financial support. Professor Dr Knoll's report and addendum add very little. He has a family network. The findings in Judge Caskie's decision at [34] stand. There is no new evidence. He is in contact with Ridwan. He spends 3 or 4 days a week at Ms Ngabu's and the rest of the time at home. He can cook and clean for her. In relation to Article 8 there are no exceptional circumstances that make his removal unduly harsh.

Appellant's submissions

54. Miss Khan submitted that she was relying on the skeleton argument, the relevant parts being;

> "Issue iv: Serious, rapid and irreversible decline
> 20. The Appellant suffers from Post Traumatic Stress Disorder, Chronic Hepatitis B, Chronic Pain. The Appellant is elderly by Nigerian standards ... The Appellant is not fit to work and is without family support. Nigeria has no functional national policy on the care and welfare of older persons ... As an older man in poor health he Appellant would also be particularly vulnerable to being infected with one of the many infectious diseases endemic in Nigeria...
> 21. The Appellant has received massage from N. Edwards. N. Edwards is of the view that the Appellant would benefit from Eye Movement Desensitization and Reprocessing at some point in the future... This treatment is unlikely to be available in Nigeria...
> 22. The Appellant takes codeine 15mg, Pregabalin 300mg, Contiflo 400mg, Sertraline 100mg, Naproxen 250mg x 3, Lansopazole 30mg and Colecalciferol 800IU. Codeine is not available in Nigeria, having been banned in 2018. The other drugs are available from online pharmacies in Nigeria and cost around NGN 854.41 per day (the equivalent of £1.54 per day). The Appellant would not be unable to access and afford the necessary medication and treatment ... Without these drugs, the Appellant would be in constant, intolerable pain. This is of sufficient severity to engage Article 3 ECHR.
> Issue v: Article 8 ECHR

...24. The Appellant is likely to face very significant obstacles to integration upon return to Nigeria. The Appellant is at risk of facing social stigmatization..., abuse and violence in mental healthcare facilities..., and accusations of witchcraft...."

55. There will be very significant obstacles on his return to Nigeria. He will struggle.

56. AM (Art 3; health cases) (Zimbabwe) [2022] UKUT 00131 (IAC) sets out the questions to answer in relation to the threshold test in Article 3 health cases. There was no finding in the decision of Judge Caskie as to whether the threshold has been met, but on the facts, the Appellant meets it. The health position has not improved since the reports were written in 2020 and 2021 and therefore no medical updates are required. He is in intolerable and chronic pain. There is intense suffering. He will find the flight very difficult. He is not fit to travel. He falls. He is seriously ill. He will be unable to access medical treatment. Nick Edwards highlighted the difficulties he had accessing food and with his living conditions. Professor Dr Knoll identifies the weak and poor health care system in Nigeria. If people do not have enough money they cannot access treatment. There will be stigma and social destitution. The most recent evidence in relation to Nigeria is the Respondent's December 2021 CPIN. His family are unable to assist. The fact that his uncle and nephew have not given oral evidence shows what little support he has. He takes a number of medications. Support for him is a long term commitment. It is unrealistic to say family and friends can support him. There is a cost of living crisis. It has to be looked at in the real world.

57. In relation to Article 8 there are very significant obstacles to his reintegration in Nigeria due to his condition. He finds it hard to manage stairs. He has mental health problems. The fact that the medication in Nigeria can be provided for £1.54 per day is not determinative as it is the total package of support that is required and not just the medication and the quality of it.

Jurisprudence on Article 3

58. It is helpful to set out the full headnote of AM (Zimbabwe) as follows;

1. In Article 3 health cases two questions in relation to the initial threshold test emerge from AM (Zimbabwe) v SSHD [2020] UKSC 17 and Savran v Denmark (application no. 57467/15):
   (1)Has the person (P) discharged the burden of establishing that he or she is "a seriously ill person"?
   (2)Has P 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"?
2. The first question is relatively straightforward issue and will generally require clear and cogent medical evidence from treating physicians in the UK.

3. The second question is multi-layered. In relation to (2)[ii][a] above, it is insufficient for P to merely establish that his or her condition will worsen upon removal or that there would be serious and detrimental effects. What is required is "intense suffering". The nature and extent of the evidence that is necessary will depend on the particular facts of the case. 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.
4. It is only after the threshold test has been met and thus Article 3 is applicable, that the returning state's obligations summarised at [130] of Savran become of relevance – see [135] of Savran.

59. I also note the subsequent guidance in THTN v Secretary of State for the Home Department [2023] EWCA Civ 1222;

> "48 ...the applicant must "adduce evidence capable of demonstrating that there are substantial grounds for believing that, if the measure complained of were to be implemented, they would be exposed to a real risk of being subjected to treatment contrary to Article 3"... Stage one of the process requires the applicant to provide strong evidence of the seriousness of the illness including the treatment involved and the consequences of removal of treatment. Those are matters which will only be within the knowledge of the applicant. She also must provide sufficient evidence to cast doubt on the availability or accessibility of treatment in the receiving state. The SSHD (or on appeal the F-TT) will be well capable of determining whether sufficient evidence has been adduced to cast doubt on the receiving state's medical facilities..."

60. MY (Suicide risk after Paposhvili) [2021] UKUT 232 (IAC) notes in the headnote that;

> "Where an individual asserts that he would be at real risk of (i) a significant, meaning substantial, reduction in his life expectancy arising from a completed act of suicide and/or (ii) a serious, rapid and irreversible decline in his state of mental health resulting in intense suffering falling short of suicide, following return to the Receiving State and meets the threshold for establishing Article 3 harm identified at [29] – [31] in AM (Zimbabwe) v SSHD [2020] UKSC 17, when undertaking an assessment the six principles identified at [26] – [31] of J v SSHD [2005] EWCA Civ 629 (as reformulated in Y (Sri Lanka) v SSHD [2009] EWCA Civ 362) apply."

61. MY set out the J test with the 5th principle as reformulated in Y (Sri Lanka) as follows;

> "16. The J test, as formulated at [26] to [32] notes: -
> "First the test requires an assessment to be made of the severity of the treatment which it is said that the applicant will suffer if removed. This must attain a minimum level of severity. The court has said on a number of occasions that the assessment of its severity depends on all the circumstances of the case. But the ill-treatment must 'necessarily be serious such that it is 'an affront to fundamental humanitarian principles to remove an individual to a country where he is at risk of serious ill-treatment': see Ullah paras [38]-[39].
> Secondly, a causal link must be shown to exist between the act or threatened act of removal or expulsion and the inhuman treatment relied on as violating the applicant's Article 3 rights. Thus, in Soering at para [91], the court said:

> 'Insofar as any liability under the Convention is or may be incurred, it is liability incurred by the extraditing contracting state by reason of its having taken action which has as a direct consequence the exposure of an individual to proscribed ill-treatment' (emphasis added).
> See also [108] of Vilvarajah where the court said that the examination of the Article 3 issue 'must focus on the foreseeable consequences of the removal of the applicants to Sri Lanka …'
> Thirdly, in the context of foreign cases, the Article 3 threshold is particularly high simply because it is a foreign case. And it is even higher where the alleged inhuman treatment is not the direct or indirect responsibility of the public authorities of the receiving state, but results from some naturally occurring illness, whether physical or mental. This is made clear in para [49] of D and para [40] of Bensaid.
> Fourthly, an Article 3 claim can in principle succeed in a suicide case (para [37] of Bensaid).
> ...
> Sixthly, a further question of considerable relevance is whether the removing and/or the receiving state has effective mechanisms to reduce the risk of suicide. If there are effective mechanisms, that too will weigh heavily against the applicant's claim that removal will violate his or her Article 3 rights".
> ...
> 18. The fifth point was reformulated as follows: -
> "[...] whether any genuine fear which the appellant may establish, albeit without an objective foundation, is such as to create a risk of suicide if there is an enforced return."

Discussion regarding Article 3

62. Miss Khan conceded that there was no finding as to whether the threshold to found an Article 3 health claim had been met. I will therefore address each of the questions posed in AM (Zimbabwe).

Is the Appellant a seriously ill person

63. Judge Caskie found that the Appellant "suffers from serious medical conditions". That does not necessarily mean he is "seriously ill". For example a person can have cancer and be at stage 1. That is a serious medical condition. But it does not mean that the individual is at that stage seriously ill.

64. The medical evidence is from his GP and the most recent report is 2 ½ years old, the other letters being around 5 years old. Given their age, all they can establish is that the Appellant at that stage had serious medical conditions which caused him great pain and discomfort. I do not agree with Miss Khan's submission that no updated medical evidence was required as there had been no change, as that is based on what the Appellant and Ms Ngabu tell me.

65. In that regard, I note that Judge Caskie stated at [34] of his decision that "*I did not find the Appellant's claim to be in fear of his former employer to be a credible or reliable one*". The reasons for that, in summary, were that his credibility was damaged by the 5 month delay in leaving Nigeria after receiving his visa ([32]), the lack of evidence his employer would know he had returned ([33]), the lack of evidence he had told his uncle and nephew why he could not return to Nigeria ([34]), his failure to advise whether the fall in November or December 2008 was

before or after his visa expired on 19 November 2008 ([35]), the failure by his employer to take action against him while he was detained and after his release from detention ([36, 37]), being untruthful regarding an email threat ([38]), and the long delay between arriving here and claiming asylum which only occurred when he was encountered by the authorities (40]). The Appellant has therefore been found to be someone who was not reasonably likely to have told the truth. Whilst of course I accept that a person can tell the truth about some matters but not others, where an adverse credibility finding is made, I am on notice that an Appellant's word does not have to be relied upon just because he says it.

66. In relation to Ms Ngabu, her evidence is essentially that they spend about half their time together. She is therefore reliant upon the Appellant to tell her what happens during the time they are not together. I have no reason to doubt that she has told the truth about what she has been told. That does not necessarily mean she has been told the truth. Even on her account, there are times when he is able to cook for her by making fish in the oven and using the microwave to heat up porridge and noodles, and he sometimes dusts for her. This undermines her evidence that it would be impossible to look after himself if he was alone in Nigeria. Because it undermines that part of her evidence, I have to be cautious about what she says about the seriousness of his illness, there being no evidence she is a health care professional able to give an independent medical opinion, and no evidence from, for example, an independent social worker.

67. As the Appellant said in oral evidence that his health has deteriorated, he is on new medication, and he has seen his GP twice, an updated medical report could have been produced to provide independent evidence to support for these contentions. A direction had been given by me at the hearing on 22 November 2023 for the filing of such additional evidence as he intended to rely on regarding the medical aspects of the appeal. The deadline was extended to 12 January 2024. An application could have been made to vary that date. An application could have been made to adjourn the hearing to update the medical evidence. None of these things happened.

68. The evidence of his current state of health, the severity of his illness, and his living capabilities could therefore have been obtained. Its absence is noteworthy. I bear in mind in this regard TK (Burundi) v Secretary of State for the Home Department [2009] EWCA Civ 40 at [21];

> "The circumstances of this case in my view demonstrate that independent supporting evidence which is available from persons subject to this jurisdiction be provided wherever possible and the need for an Immigration Judge to adopt a cautious approach to the evidence of an appellant where independent supporting evidence... is readily available within this jurisdiction, but not provided. It follows that where a Judge in assessing credibility relies on the fact that there is no independent supporting evidence where there should be supporting evidence and there is no credible account for its absence commits no error of law when he relies on that fact for rejecting the account of an appellant."

69. There is no medical report confirming a diagnosis of PTSD as it has not been established that Nick Edwards is qualified to make a diagnosis and only refers to the Appellant having symptoms of PTSD, Dr Bradley does not refer to PTSD, and there is no evidence from a Consultant Psychiatrist to that effect. There is no medical evidence to support the assertion that the Appellant has memory loss in the absence of which it has not been established it is reasonably likely that he has.

70. There is no evidence from a Consultant Psychiatrist relating to depression or anxiety or indeed any other mental health condition. There is therefore no current assessment of the severity of any mental illness or symptoms as manifested in the Appellant. There is no evidence he has ever been hospitalised as a result of any mental illness or that he is sufficiently ill to need to liable to be detained in hospital for treatment or assessment.

71. There is no suggestion that the Appellant's haemorrhoids are a serious medical condition.

72. I accept that Hepatitis B and prostatitis are medical conditions which can be serious and are the serious medical conditions referred to by Judge Caskie. There is no report from a Consultant assessing the severity of the Hepatitis B as manifested in the Appellant or regarding the pancytopenia. There is no cogent evidence the Appellant is seriously ill with it.

73. The most serious condition the Appellant appears to have, and the one that appears to cause most concern is the chronic prostatitis which was caused by the car accident in Nigeria that penetrated the perineum and appears to have been exacerbated by falling in icy conditions in the United Kingdom. I am aware that the perineum is the small patch of sensitive skin between the genitals and anus. It is this which also appears to be the root cause of his mental health issues. I accept that this has caused a great deal of pain and discomfort for 16 years, and regrettably will continue to do so. One for example can have great pain and discomfort from toothache which can be for a significant period of time, but no one would suggest that having toothache is a manifestation of a serious illness. Having a great deal of pain and discomfort for 16 years does not mean he is seriously ill as he does not require hospitalisation for any extended period, is able to spend 3 or 4 days a week with Ms Ngabu who he sometimes helps, and he can provide care for himself the rest of the time as there is no evidence he has a carer to assist.

74. For all these reasons the Appellant has failed to establish he is seriously ill.

75. Having failed to establish he is seriously ill I do not need to consider the second question in AM (Zimbabwe). I will however do so for the sake of completeness.

Is there an absence of appropriate treatment

76. It is not argued that there is a complete absence of treatment for his ailments in Nigeria. The challenges within the health service both public and private are well documented above in Professor Dr Knoll's report and the Respondent's 2021 country information note and I will not repeat it here.

Would he be able to access the treatment

77. Professor Dr Knoll's opinion is predicated on the Appellant's personal circumstances being as claimed. For the reasons that follow, I do not accept that they are as claimed. In relation to support in Nigeria, I note that he has adult children, nephews and nieces, and a friend Dauda there. He is in touch with Ridwan and Dauda. He is also in touch with the proprietor of the college Ridwan lives at. Dauda is in touch with the Appellant's daughter. There is no evidence from Ridwan, Dauda, or the proprietor of the college that they cannot or will not assist the Appellant. Nor is there evidence directly from Dauda of the alleged family estrangement. Nor is there any evidence as to why Ridwan could not have provided a letter setting out his position, as being deaf does not mean he cannot write. I note he is studying. He is plainly able to access information and use technology. It has not been established he is not working. It has not been established the school proprietor would not allow the Appellant to live there with Ridwan. It has not been established by Dauda that the Appellant cannot live with him. All this evidence could have been adduced easily as the Appellant is in touch with all these people. Its absence damages the Appellant's credibility as explained in TK (Burundi). Whilst I accept that TK (Burundi) refers to evidence "readily available within this jurisdiction", I am satisfied it applies equally to evidence that can be readily available from outside this jurisdiction especially in this era of modern means of communication being so readily available, TK (Burundi) being some 15 years old. Given the Appellant's lack of credibility in relation to other aspects of his account I do not accept what he says just because he says it.

78. I am therefore satisfied that the Appellant has support from both family and Dauda available in Nigeria, and that he can be provided with accommodation. As there is no cogent evidence they would not be able to assist him financially, I do not accept that the £1.54 per day (which amounts to £10.78 per week or £562.10 per year) to pay for the medication would be a significant burden for his support network in Nigeria. Even if the skeleton argument is badly drafted and it meant to say it was £1.54 per day per medicine, that only amounts to 1.24 per day without the Codeine which is not available in Nigeria and amounts to £3,372.60 per year. I do not accept he has established that the cost of any additional medical support (even considering the higher drug cost figure) would be outside the reach of his Nigerian support network. Whilst it is clear that the health service face challenges in Nigeria, and reliance is placed in large part on private health care, he has failed to establish it is not available or he cannot with assistance afford it.

79. There is no suggestion that if in Nigeria he would be unable to attend such clinics as required. I note he attends the doctor here and attended the hearing. Local travel is therefore possible. He has support in both Lagos and Saki and he has failed to establish that the facilities required are outside a range of reasonable distances to access from either.

80. While considering the question of travel, I note the evidence from Dr Bradley that "he would find the experience of a long flight very difficult….I am unsure if he could cope with remaining seated due to the pain". The Appellant plainly has difficulties both siting and standing for long periods. However he would not have to do either for a long period as he can sit and stand on the plane. There is no reason to suggest that the Respondent would not purchase more than 1 seat on the plane for the Appellant to enable him to lie down, or that removal enforcement officers they would not be supportive by allowing him to lie down when required across the seats. I accept it is imperfect, but people do many helpful things for others in pain. It has also not been established that suitable short term stronger painkillers could not assist to alleviate pain during travel. I accept it may be very uncomfortable, but I do not accept that the evidence adduced established that the discomfort on the journey is such that it amounts to "a serious, rapid, and irreversible decline in his or her state of health resulting in intense suffering". I will deal with the Article 8 issues on this shortly.

81. In relation to the support he can receive from the United Kingdom. I note that Ms Ngabu that she is in receipt of Universal Credit which after the deduction of her housing and living costs leaves her about £358 per month to pay for food and other essentials. That is some £90 per week. I accept she sometimes gives the Appellant £10. She also gives him meals. If he was not here she would not have to give him meals. I am satisfied that given the savings in food and given the occasional sums she already gives him she could afford to provide him with £10 per week on an ongoing basis to assist.

82. I place no weight on the letters from Mr Ajani or Mr Talabi as neither signed the letters and neither has attended to have their evidence tested despite that being a readily available option that causes little inconvenience. That evidence is "in country" and is readily available as explained in TK (Burundi). The Appellant has therefore failed to establish that neither would be able or willing to provide additional financial support to him in Nigeria as all I have is the Appellant's word, which for the reasons I have already given, is insufficient to establish what he says just because he says it.

83. As rightly pointed out by Miss Khan, medication is not the only cost associated with his treatment. Given the failure to establish what additional sums would be required for other costs such as accommodation (if any) food, transport, or treatment other than medication, the Appellant has failed to establish he would be unable to access the treatment available, even given the challenge for all Nigerians accessing it.

84. He has therefore failed to establish there is no appropriate treatment in Nigeria, or that he could not access it, those being the second and third AM (Zimbabwe) questions.

Would he be 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

85. I note in this regard the guidance in THTN and MY set out above at [59-61]. I will not repeat it. I have already set out my concerns about the lack of up to date medical evidence, and the lack of reports from Consultants in the relevant fields. I will not repeat those concerns. They apply equally here as they do earlier.

86. The report from Professor Dr Knoll is predicated on a lack of access to suitable support and treatment. I have already determined those issues. Given the support he is likely to have, there is no real risk he will face social stigmatization, abuse and violence in mental healthcare facilities, or be accused of witchcraft. The medical reports are old and do not identify that there will be a serious, rapid and irreversible decline in his state of health resulting in intense suffering, or to a significant reduction in life expectancy as they are predicated on a lack of access to suitable support and treatment which I have already determined will be likely to be available to him. I will not repeat those findings. I note in this regard the lack of evidence from Consultants in Nigeria in the relevant fields regarding specific access to the treatment available for his conditions and their affordability as opposed to the generic evidence from Professor Dr Knoll. Her opinion as to the likely risks therefore carries little weight. The Appellant will clearly suffer from chronic pain in the same way he does here.

87. Given the findings I have made, I am not satisfied it that the threshold for establishing Article 3 harm has been met. For the sake of completeness however I will consider the 6 questions identified in J.

88. It has not been established he will suffer severe treatment if removed as he will have access to support from family and a friend, and access to medical care. The change in support regimes is not "an affront to fundamental principles". There is therefore no causal link as there is no inhuman treatment in removal. I note the particularly high threshold for an Article 3 foreign case and note that the Appellant's health challenges are not from a naturally occurring illness but the root of them is a motorbike accident that was exacerbated by a slip in icy conditions. The fear of return the Appellant has is without an objective foundation, and not such as to create a risk of suicide if there is an enforced return as he has support that will assist him reintegrate and overcome those fears especially when he will be able to be reunited with family including his children which will greatly enhance his family life and with Dauda. Finally, there is evidence of the availability of effective mechanisms in Nigeria to reduce that risk given the presence of support from family and a friend, and the availability of medical treatment and his ability to access it.

89. The Appellant has therefore for all the above reason failed to establish that his Article 3 rights will be breached by his removal.

Jurisprudence on Article 8

90. I bear in mind from Akhalu (health claim: ECHR Article 8) [2013] UKUT 00400 (IAC) headnote (1) that;

> "the countervailing public interest in removal will outweigh the consequences for the health of the claimant because of a disparity of health care facilities in all but a very few rare cases,"
> and (2) "when weighed against the public interest in ensuring that the limited resources of this country's health service are used to the best effect for the benefit of those for whom they are intended, those consequences do not weigh heavily in the claimant's favour but speak cogently in support of the public interests in removal."

91. I note also at [4] of Razgar v Secretary of State for the Home Department [2004] UKHL 27 that;

> "removal cannot be resisted merely on the ground that medical treatment or facilities are better or more accessible in the removing country than in that to which the applicant is to be removed".

Discussion regarding Article 8

92. I will not repeat the findings I have already made. In applying the law to the findings in relation to Razgar and the criteria of 117B of the Nationality, Immigration and Asylum Act 2002, he does not live with Ms Ngandu. They only spend half their time together. Accordingly he has failed to establish they are in a relationship that amounts to family life. In any event her leave to remain as identified in the skeleton argument at [23] is limited and accordingly they do not fulfil the requirements of EX.1. (b) of Gen 1 of the Immigration Rules. Even if she was a qualifying person and it does interfere with their family life, I place little weight on it as it was established when he was here unlawfully. She will be adversely affected by his removal, but I am satisfied she will be able to receive such professional support and support from the Church as is required to ensure her needs are met. In this regard I have considered Beoku-Betts v Secretary of State for the Home Department [2008] UKHL 39.

93. The proposed removal will interfere with the exercise of his right to respect for his private life but I attach little weight to it as it was established when he was in the United Kingdom unlawfully.

94. Even given the low threshold, I do not accept that such interference has consequences of such gravity as potentially to engage the operation of Article 8 as he can be supported by close family and a close friend in Nigeria and access treatment as required for the reasons I have already given, and will be in a country where he speaks the language, and understands the culture having lived there for 42 ½ years. The 15 years he has spent here does not mean he is westernised or that he has lost his understanding of Nigerian life as he has remained in touch with people in

Nigeria throughout. I have of already considered how issues relating to the flight can be ameliorated.

95. The interference with the exercise of his right to respect for his private and family life is in accordance with the law as he does not meet the immigration rules.

96. Such interference is necessary in a democratic society in the interests of national security as the maintenance of effective immigration control is an essential feature of that. It is also for the economic well-being of the country as he is a burden on the public purse given the treatment he is on, there being no evidence he pays privately for it.

97. Had proportionality been reached, which it has not, I am satisfied that his removal is proportionate to the legitimate aim identified as he does not meet the immigration rules, and he can reintegrate in Nigeria without there being any very significant obstacles as he will be considered an insider and have a reasonable opportunity to participate in life there and operate on a day to day basis as he does here (Secretary of State for the Home Department v Kamara [2016] EWCA Civ 813 and Immigration Rules Appendix Private Life at PL [5.1]). His ability to speak English is a neutral factor. I have of course borne in mind in balancing the factors in his favour the main ones being that he has been here for 15 years, has medical conditions one of which causes chronic pain for which such treatment as can be given is being given here, and he has a long lasting friendship with Ms Ngandu which will inevitably be severely disrupted if not severed entirely by his removal.

Notice of Decision

98. I dismiss the Articles 3 and 8 human rights appeal.

Laurence Saffer

Deputy Judge of the Upper Tribunal
Immigration and Asylum Chamber
10 June 2024