IAC-FH-AR-V1

Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: AA/02149/2015

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On 4 March 2016	**On 12 April 2016**

Before

DEPUTY UPPER TRIBUNAL JUDGE HILL QC

Between

T P O
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Ms M C Benitez, Counsel, instructed by Duncan Lewis & Co Solicitors
For the Respondent: Mr L Tarlow, Home Office Presenting Officer

DECISION AND REASONS

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1. This is an appeal brought with the permission of Upper Tribunal Judge Plimmer concerning a determination promulgated on 2 September 2015 by First-tier Tribunal Judge Ford.

2. The appellant is a national of Nigeria who has a lengthy and complex immigration history including asylum and refugee status claims, neither of which were considered to have any substance.

3. The hearing in the First-tier Tribunal focused on the appellant's medical history and in particular the contention that were she to be returned to Nigeria her health would be put at risk.

4. The appellant suffered a cardiac arrest on 27 June 2011, and was diagnosed with "a life threatening arrhythmia". She was fitted with an implantable cardioverter defibrillator (ICD) designed to prevent a repetition. The judge records:

> "The appellant has supplied two letters dated June and July 2013 from cardiologists in Nigeria concerning the availability of suitable treatment for [the appellant's] condition there. I was surprised not to see anything more up-to-date."

5. Dr Osunki, a cardiologist at the National Hospital in Abuja indicates "a very high likelihood of fatality in the event of a failure". He states:

> "There would be no means of detecting any fault in the functionality of the device or knowledge of the wire frame to the heart. There is no provision for replicable components of the device in Nigeria. If the device were to become faulty or if a battery were to become depleted this would not be replaceable in Nigeria and the appellant would be at risk of sudden death."

He refers to the appellant's mother dying from a related condition.

6. At the heart of this appeal in this case is the allegation that the judge failed to take into account relevant expert evidence and in coming to his conclusion failed to give any or any adequate reason for seemingly rejecting the expert evidence which was before him.

7. This criticism relates to three key matters. The first is an alleged misreading of an email from Miss Denise Coley, dealing with equipment which might be available in Nigeria. Miss Coley evidence, it is said, is misstated in the course of the determination. The judge relates at paragraph 32 that Miss Coley

> "... is a marketing professional with St Jude Medical UK Limited. In her email at page 346 of the bundle she states that there is only one clinic in Nigeria which has a Merlin programmer supplied by the US. She says 'at this time I cannot guarantee that this programmer has the appropriate version of software to support fortify ICDs'. She states that the surgeons have had little training on ICDs because none are currently implanted in Nigeria. I have not seen any follow up correspondence with the clinic in question to ascertain whether the

> Merlin programmer that is available in Nigeria is suitable for the appellant's ongoing monitoring or not."

8. At paragraph 33 the judge continues

> "Miss Coley was asked whether hospitals in Nigeria have access to remote follow up and she says 'Nigeria is not supported on remote care as there are no ICD implants'. She says that this does not rule out the possibility of remote care being provided if there is an individual in Nigeria with an ICD implant."

9. I was taken by Ms Benitez to the full content of Miss Coley's email which reads as follows:

> "The clinics in Nigeria all have the older programmers which do not support the follow up of ICDs apart from one clinic which has a Merlin programmer supplied by the US. At this time I cannot guarantee that this programmer has the appropriate version of software to support fortify ICDs [...] the surgeons have had little training on ICDs as none are currently implanted in Nigeria." (emphasis added)

10. The second matter relied upon by Miss Benitez are letters from clinicians in Nigeria. In a letter dated 3 June 2013 from Dr A O Salami, a consultant cardiologist at Lagos State University Teaching Hospital, says this of the appellant:

> "The only current known treatment is with an implantable cardioverter defibrillator. This acts as a safe [sic] net and continuous monitoring of the heartbeat. The implantable cardioverter defibrillator is highly specialist. This supportive therapy is not available in Nigeria. However patient has been benefiting from this supportive therapy abroad with good response to treatment and any improxity to her cardiologist or if the patient travel out of the country where this facilities are not available may exacerbate her illness and lead to sudden death."

11. The other letter is from a Dr D A Osunkwo who is a chief consultant cardiologist at the National Hospital in Abuja and he makes the following points.

- There is a lack of the cardiological expertise in Nigeria to diagnose this very rare heart condition
- There is lack of facilities and resources that will be required for monitoring and follow-up
- There is a lack of research into this condition in Nigeria. It is still a subject of ongoing clinical research in the developed world and it is currently poorly understood. The patient and her family are currently subjects partaking in a number of UK based research centres working on this condition.
- There is a lack of the medical technology for monitoring the interrogation of ICD, hence there would be a very high likelihood of fatality in the event of a failure. There would be no means of detecting any fault in the functionality of the device or knowledge of the wire frame to the heart. There is no provision for the replaceable components to the device in Nigeria.

- If her device were to become non-functional or if the battery depleted this would not be replaceable in Nigeria and she would be at risk of sudden death. Sadly I was informed that her mother died of an unexpected sudden death from a related condition.
- There is no known effective tablet treatment for this condition and therefore there will be a high risk of fatality and poor prognosis if the treatment of her condition were to be transferred to Nigeria. I strongly recommend that a condition of this nature should be treated in the UK where the technology and expertise are available for ongoing monitoring and follow up for the reason of preservation of the patient's life as opposed to Nigeria.

12. The third matter pursued by Miss Benitez is that the judge gave inadequate consideration to the content of a letter dated 22 May 2013 from Dr A D Staniforth, a consultant cardiologist at Nottingham University Hospitals NHS Trust. The salient part reads as follows:

> "On the basis of current medical knowledge the appellant has an indefinite/ lifelong ICD prescription. The device needs ongoing lifelong clinical monitoring. In Nottingham we perform six to twelve monthly clinic based tests. Our patients are also signed up to remove wireless monitoring so we can know within 24 hours whether a shock has occurred or a life threatening device/lead fault is developing. Wireless monitoring is internet based and requires a telephone line. The monitoring and follow up of ICDs is highly specialist. An ICD battery/generator has an expected life span of seven to nine years at which point replacement is required. The ICD also has a wire which is implanted in the heart. These are subject to wearing out and need replacement every ten to fifteen years. When replacing an ICD lead in a young patent it is customary to extract the existing lead. This too is a highly specialist procedure that requires an onsite cardiac surgery backup. An ICD generator has a hardware cost of around £12,000. Procedure costs for ICD replacement would approach £20,000. Hitherto the level of expertise for ICD follow-up within the UK has only been available with tertiary/university centres. Over the last couple of years this has started to spread to some of the larger district general."

13. In my assessment, although the grounds of appeal are dressed up as an allegation of error of law, the real thrust of the appellant's argument before me is a disagreement on the factual conclusion to which the judge came and to which, in my opinion, he was entitled to come. The decision is careful, balanced and fully reasoned. When pressed, Miss Benitez focused her criticisms on paragraphs 67, 68, 71, 80, 81 and 85 of the decision, indicating that in her submission those paragraphs individually and collectively did not properly summarise the evidence. Ms Benitez further contends that in the course of the determination no reasons are given for departing from the expert evidence.

14. I reject those criticisms. The judge carefully rehearsed, assessed and weighed the expert evidence and then brought his material findings into the proportionality exercise which he was required to undertake in determining the appellant's human

rights claim. His conclusions might appear to be harsh, but judges are required to make objective and dispassionate evaluations and should not be swayed by sentiment. The Upper Tribunal cannot interfere with findings of fact which were open to the Judge of the First-tier Tribunal.

15. However, paragraph 71 reads as follows:

> "The appellant argued that ongoing monitoring, ICD device checks to be carried out remotely every three months, and annual check ups at which she need to be present are all essential to her health and wellbeing. She argues that she can only receive this treatment and monitoring if she is in the UK. In an email at page 346 of the appeal bundle from Miss Coley who works for St Jude Medical, manufacturer of the Merlin programmer used by the appellant, she states that there is a clinic in Nigeria which has a Merlin programmer supplied by the US. The appellant has not followed this up or if she has she has not produced the evidence and I am not satisfied that she cannot have access to the programmer for monitoring purposes if she is in Nigeria. Nor am I satisfied that the programmer is unsuitable for monitoring the appellant's particular ICD. I can see no reason why the appellant cannot travel overseas for an annual check-up. Although the appellant and her sisters suggested that the appellant had had several genuine scares with her ICD since it was fitted requiring medical intervention I could see no medical evidence to support this and although I accept that the appellant and/or her family may have asked for medical checks to be conducted on her ICD I am not satisfied that those checks were medically necessary." (emphasis added)

16. The second part of paragraph 80 reads as follows:

> "[The appellant's] prognosis is good and she has received all relevant treatment for the time being. Her only real complaint is that the monitoring of the functioning of her ICD cannot be carried out in Nigeria as the expertise and equipment are lacking. As stated above, I am not satisfied that this is the case as suitable monitoring equipment may be available in a private clinic. The appellant can continue to travel overseas for any actual treatment." (emphasis added)

17. An independent and free-standing criticism is made that by use of the word "may" in this passage, the judge is being drawn into speculation, and it seems to be ill-informed speculation because the judge has failed to differentiate between a programmer (which is mentioned in paragraph 71) and monitoring equipment which is the subject of conjecture in paragraph 80.

18. Not without considerable hesitation, I am narrowly persuaded that this discrete matter of speculation amounts to a material error of law. It is pure speculation which is not grounded by the evidence that the judge considered and which he assessed fully and comprehensively. It confused programming equipment which Miss Coley addressed and monitoring equipment which she did not.

19. I have regard to the remarks of Lord Justice Moses giving judgment in **MM (Zimbabwe) [2012] EWCA Civ 279** in which he stated:

> "The only case that I can foresee where the absence of adequate medical treatment in the country to which a person is to be deported will be relevant to Article 8 is where it is an additional factor to be weighed in the balance with other factors which by themselves engage Article 8. Suppose in this case the appellant had established firm family ties in this country, then the availability of continuing medical treatment here coupled with his dependence on the family here for support together established private life under Article 8. That conclusion would not involve the comparison between medical facilities here and those in Zimbabwe. Such a finding would not affirm the principle expressed above that the United Kingdom is under no Convention obligation to provide medical treatment here when it is not available in the country to which the appellant is to be deported." (emphasis added)

20. I am conscious that the totality of the evidence – as carefully assessed by the judge – militated in favour of the conclusion to which he ultimately came and that even had the judge not wrongly speculated upon the availability of monitoring equipment in Nigeria he might very well have come to precisely the same disposal. The appellant is perfectly able to travel for periodic check ups and for treatment. It is solely in relation to continuous daily monitoring where the judge's otherwise impeccable analysis lapses momentarily into speculation. This is a factor which featured in the proportionality exercise and, in all the circumstances, the interests of justice require that the First-tier Tribunal decision be set aside and the matter be remitted to a different First-tier Tribunal Judge for a redetermination solely of the human rights claim. The First-tier Tribunal' findings on asylum grounds, humanitarian protection grounds and under the Immigration Rules are preserved.

21. Mindful of the very narrow and somewhat technical basis on which this appeal has succeeded, the appellant should be aware of the real prospect that a rehearing may nonetheless come to the precisely same conclusion as the first judge did.

Notice of Decision

Appeal allowed on human rights grounds.

Human rights appeal remitted to the First-tier Tribunal for a rehearing.

All other elements of the appeal to stand dismissed.

Direction Regarding Anonymity – Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008

Unless and until a Tribunal or court directs otherwise, the Appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him or any

member of their family. This direction applies both to the Appellant and to the Respondent. Failure to comply with this direction could lead to contempt of court proceedings.

Signed *Mark Hill* Date 24 March 2016

Deputy Upper Tribunal Judge Hill QC