



Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: IA/32497/2014

THE IMMIGRATION ACTS

Heard at Field House
On 15 May 2017 & 21 June 2017

Decision & Reasons Promulgated
On 26 June 2017

Before

UPPER TRIBUNAL JUDGE McWILLIAM

Between

LMB
(ANONYMITY DIRECTION MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Ms D Revill, Counsel instructed by M & K Solicitors

For the Respondent: Mr T Melvin, Home Office Presenting Officer

DECISION AND REASONS

1. The Appellant is a citizen of Nigeria and her date of birth is [] 1957. She came to the United Kingdom in 2005 on a visit visa. The Appellant remained here after the expiry of her visit visa. She made an application in 2008 for leave to remain which was refused by the Respondent on 14 May 2009. She was served with an IS.151A on 26 July 2014. The Appellant appealed against a decision of 30 July 2014 to remove her. Her appeal was dismissed by the First-tier Tribunal in 2015. This decision was

set aside by the Upper Tribunal and the matter was reheard by Judge of the First-tier Tribunal Andrew on 13 April 2016. He dismissed the appeal in a decision that was promulgated on 19 April 2016. Permission to appeal against that decision was granted by Deputy Upper Tribunal Judge Taylor on 7 December 2016. The matter came before Upper Tribunal Judge Reeds on 22 March 2017 who concluded that Judge Andrew had materially erred and set aside the decision to dismiss her appeal under Articles 3 and 8. Judge Reeds made a series of directions. The matter came before me for a substantive hearing on 15 May 2017.

2. Neither party complied with the directions of Judge Reeds in respect of the filing and service of further evidence pursuant to Rule 15(2A) of the 2008 Procedure Rules. At the start of the hearing Ms Revill indicated that there had been a significant change in circumstances in respect of the Appellant and her son, DB, but there was no further statements of evidence and her intention was that the new evidence would be given during examination-in-chief. I did not consider this position to be satisfactory. I directed Ms Revill to take further witness statements from the witnesses and to serve those on Mr Melvin so that he could consider the same. Ms Revill submitted an eight-page skeleton argument on the morning of the hearing (contrary to the directions of Judge Reeds). I expressed concern to Ms Revill about how the Appellant's case was presented, in the light of the fact that there was no comprehensive bundle before me. The evidence had been served in a piecemeal fashion and there were documents submitted which did not on the face of it appear to be relevant.
3. At the hearing on 15 May 2017, Ms Revill agreed that she would prepare a comprehensive list of all the evidence on which the Appellant seeks to rely for the purposes of this appeal. I directed a bundle with a comprehensive index should be served and filed on the Tribunal not later than 29 May 2017. A bundle (AB) was served and filed accordingly. Ms Revill did her utmost to assist the Tribunal and I make no criticism of her.
4. Mr Melvin relied on a skeleton argument that was sent to the Tribunal on 5 May 2017. However, he made an application under Rule 15(2A) 2008 to adduce further evidence, namely evidence relating to an outstanding NHS debt totalling £33,309.03 to the Royal Brompton & Harefield NHS Foundation Trust, a British Cardiovascular Society Report of Fitness to Fly and General Practice Notebook (Ref British Heart Foundation) entitled Fitness to Fly. The Respondent relies on the general grounds for refusal in respect of the evidence of the outstanding NHS debt. However, the application was not made in a timely fashion in accordance with 15A (2) of the Procedure Rules. Ms Revill opposed the application. In my view, the evidence is material to the issues in this case. Ms Revill was not able to identify any unfairness or prejudice caused to the Appellant by its late service. I admitted the evidence.
5. Mr Melvin submitted written submissions on 21 June 2017. At the hearing on 21 June, after Mr Melvin's submissions, sadly the Appellant was taken ill and my understanding is that she was taken to hospital in an ambulance. Regrettably there

was no effective air conditioning at Field House on what was an extraordinarily hot day.

The Appellant's Evidence relating to her medical condition

6. At the hearing Ms Revill stated that there was no reliance on any of the documents that were not contained in the AB which comprises 181 pages. I have considered all of the documents in the AB. I have recorded what I consider to be the most important evidence, but I have considered all the evidence in the AB. The following are those referred to by Ms Revill include:-

Letter from Dr Kumar to Dr Gillham of 7 August 2008 (AB page 61)

Dr Kumar states as follows: -

“Being a known patient of significant LV dysfunction secondary to dilated cardiomyopathy, although she is currently free of signs of failure she would be at a higher risk of developing symptomatic heart failure at high altitude. If her journey is essential and unavoidable I would recommend that she informs the details of her illness to the light authorities so that if necessary, she might be able to get some oxygen supplements. During her stay in Nigeria, whenever she is symptomatic she should seek immediate medical advice”.

A letter “To Whom It May Concern” from Dr J George, a GP registrar of 27 August 2014 (AB page 51-53).

The author indicates that the letter has been prepared at the request of the Appellant and with her consent and the letter records the Appellant's medical conditions as follows: -

- “1. Paroxysmal atrial fibrillation (irregular heartbeat) for which she is on warfarin a blood thinner and requires weekly blood tests.
2. Non-ischaemic dilated cardiomyopathy (pathological enlargement of the heart) – in my recent consult it appears that symptom control has destabilised in the recent past as manifested by ongoing episodes of dizziness, easy fatigability, exertional dyspnoea (shortness of breath), cardiac chest pain and palpitations (racing heart). She is awaiting a cardiology review for which she has been referred.
3. For conditions 1 and 2 (each on its own and synergistically worse together) – she is at risk of fatal ventricular tachycardia which could lead to a cardiac arrest. She does have an implantable cardiac defibrillator (ICD) which I understand also provides on demand pacing. This requires frequent interrogation to ensure its integrity

which is done at the specialist cardiac centre in Harefield Hospital. In addition, I understand that the ICD device automatically status reports on-line daily to the cardiac centre as well.

4. She also has asthma on step 2 treatment with long acting inhaled steroids.
5. She suffers with stage 3 chronic kidney disease.
6. She has moderate medical compartment degeneration of her left knee. This leaves her with intermittent significant knee pain. Although she was considered for arthroscopic repair it was felt ultimately that in view of her significant medical comorbidities, the benefit of anthroscopic surgery was outweighed by the risks involved."

The GP goes on to state as follows: -

"The combination of the aforementioned conditions in my opinion would leave her unsuitable to drive or to undertake long distance travel and especially air travel. She would need cardiology review and clearance from them if she were to undertake any of the aforementioned activities".

Letter from Dr Travill, a Consultant Cardiologist at Luton & Dunstable University Hospital to the Appellant's GP, Dr Gillham of 19 November 2014 (AB page 49-50)

The letter states that the Appellant has dilated cardiomyopathy and had implantation of CRTD device in 2009 and was seen by Dr Travill for review. Dr Travill states that the Appellant continues to experience dizziness which can occur at any time and she had given him an account of a recent occurrence of dizziness and breathlessness. Dr Travill indicates that mobility is currently limited to a maximum of 80 yards on the flat due to breathlessness. It is also stated that she experiences paroxysmal nocturnal dyspnoea three times a week and sometimes more, and that this is associated with a cough. Dr Travill also states that on some occasions the Appellant may struggle for breath after sitting for two hours. He lists the Appellant's medication and he states as follows: -

"She asked if it was possible for her to fly to Nigeria. I would have significant reservations about this in the context of flying when she may become cardiovascularly compromised and would certainly be at increased risk. In addition, when in Nigeria the facilities to manage her defibrillator are not widespread or easily accessible".

Letter from Dr I Merinopoulos to the Appellant's solicitors of 18 June 2015 (AB page 95)

The letter reads as follows: -

“Dr Travill said that he would strongly advise against [the Appellant] travel to Nigeria. The worst-case scenario if Mrs B travels to Nigeria in the absence of appropriate facilities to manage her device, would be a possible complication to happen with the device which might not be possible to manage in that country. For example, it is possible for the device to start ‘firing’ (providing ICD shocks) unexpectedly and in the absence of enough medical expertise to manage that situation; this can put her life at risk”.

Background Evidence

7. The Appellant relied on the following:-

Letter from Dr Ndom of the Federal Medical Centre in Nasarawa State in Nigeria of 12 September 2014 (AB page 63)

The author states that they do not have the required expertise to handle the home heart monitoring machine which is to be directly connected to a landline phone and with readings being transmitted to the centre where it will be monitored. It is also noted that this would require constant electricity supply. It is stated that the hospital ambulance is not equipped to handle related emergencies and that there is concerns about getting genuine medication because of the circulation of fake drugs. It is summarised that assuming the facility and the logistics are available, the patient to sustain treatment would need access to considerable funds.

The Fight Against Fake Drugs by NAFDAC in Nigeria (44th International Course in Health Development) ICHD (September 24, 2007 - September 12, 2008, author Olike Chinwendu) (AB page 76-84)

The report at page 144 of AB1 addresses the problem of fake drug proliferation in Nigeria which has, according to the author, affected the credibility of the healthcare system and can exert very harmful effects on the consumer resulting in illness; disability and even death and anyone can be a victim.

Article from www.howafrika.com (undated)(AB page 88-94)

The article is entitled “Meet Nigerian, Dr Olurotimi Badero, the world’s only combined heart and kidney specialist doctor”. The Appellant relies on the article with specific reference to page 92 where in an interview with Dr Badero, a Nigerian US Based cardiologist, he stated that in Nigeria “devices like pacemakers and defibrillators are not available to manage some heart conditions.”

The Report of Joint British-Danish Fact-Finding Mission to Lagos and Abuja, Nigeria 9-27 September 2007 and 5-12 January 2008 of 29 October 2008 (AB Page 126-181)

The Appellant submitted this document in support of her appeal and specific reference is made to paragraph 6.11 which is entitled "Treatment for heart conditions and cardiovascular diseases" and which reads as follows: -

"The doctor stated that the most common type of cardiovascular disease that Nigerians suffer from is hypertension (high blood pressure), with 8%-10% of Nigerians suffering from the condition. Drugs that can reduce blood pressure are available but are very expensive and are not affordable by the majority of the population. There are no specialist cardiovascular or cardiothoracic centres in Nigeria, but treatment is available for a wide variety of cardiovascular conditions and diseases, including congenital heart conditions. People suffering from coronary heart disease or people who have had heart attacks can be treated, in general, but coronary artery by-pass and angioplasty operations are not available in Nigerian hospitals. In general, invasive heart operations are not available but heart valve defects, atrial septal defects, and aneurysms can be treated. Pacemakers can be installed and therefore patients with certain types of arrhythmias (abnormal heart rhythm) can be treated. There is inadequate treatment available in Nigerian hospitals for people suffering from primary cardiomyopathy (enlargement of the heart cavity). This condition in its end-stage can be cured through the use of a heart transplant but heart transplant operations are not yet available in Nigerian hospitals."

8. The Respondent relied on the following:-

The General Practice Notebook

The Respondent relies on guidance following pacemaker implantation which reads as follows:-

"Fly after two days if no pneumothorax. In the event of pneumothorax, flying should be deferred for two weeks following complete resolution."

and the guidance following ICD implantation and highlights the "lay explanation" which reads as follows: -

"If you have had a defibrillator, the same advice for pacemakers (above) applies but, in addition you should not fly after the ICD has delivered a shock until your condition is concerned stable"

and the "restriction guidance" which is given for following ICD implantation is as follows: -

“The same advice as for pacemakers above but, in addition, rhythm instability should be treated.”

British Cardiovascular Society Report entitled “Fitness to Fly for Passengers with Cardiovascular Disease”

This article dates back to 2010. The salient parts of it are contained in the summary and reads as follows: -

“Following this review of evidence and after due consideration, it is clear that there are few cardiovascular conditions that warrant the denial of fitness to fly as a passenger. Given the right aircraft, on board equipment and appropriately qualified and experienced escort personnel, aircraft can act as flying intensive care units and carry extremely ill passengers. For those with cardiovascular disease who are not cortically ill but who wish to fly on commercial aircraft, the aircraft environment does not pose a significant threat to their health. It is only when their underlying condition is associated with a significant risk of acute deterioration that reasonable restrictions should apply. For those of the more severe end of the spectrum of their specific cardiovascular condition, services exist to help make the journey more easily and safely.

... Passengers are advised to plan their arrival at the airport in plenty of time to avoid having to rush to warn the carrier and/or airport authority of any requirements for assistance, including requirement for in-flight oxygen, well in advance of the date of departure. They are strongly advised to ensure they have an appropriate supply of their medication, a clear list of the medications and doses they take and a letter of explanation from their doctor regarding their condition, drugs, allergies and devices (e.g. pacemaker)”.

9. The report goes on to consider pacemakers and ICDs at paragraph 8 reads as follows:-

“8.1.1 In the UK over 40,000 new patients receive an implanted pacemaker or ICD each year. The majority of these devices are conventional pacemakers, but there are an increasing number of cardiac resynchronisation therapy (CRT) pacemakers and ICDs, with or without CRT capability.

8.1.2 It is estimated that there are currently 380,000 patients with pacemakers, 6,000 patients with CRT pacemakers and 33,000 patients with ICDs (including 7,000 with CRT capability) in the UK. (D. Cunningham, Personal Communication, 2009). The majority of pacemaker recipients are elderly (mean age at implant 75.5 years), but patients may receive a pacemaker at any age from infancy to adult life.

...

- 8.1.4 Patients receiving CRT and ICDs tend to be younger (mean age at implant 69.9 and 62.5 years, respectively) and more often have sic underlying cardiac disease such as previous myocardial infarction, cardiomyopathy, impaired left ventricular function and heart disease. When assessing the patient's fitness to fly, the nature and stability of these underlying conditions require careful consideration and may be of greater significance than the presence of the device.
- 8.1.5 Although the majority of patients with an implanted device may travel safely by air, there are a few specific issues that should be considered before travel and a number of concerns for which the patient may require guidance or reassurance."

The OGN Nigeria 2013

Neither party produced this. However, Ms Revill referred to it in her submissions. I have considered this document and the salient paragraph that reads:-

"5.2 Caseworkers should give due consideration to the individual factors of each case and refer to the latest available country of origin information concerning the availability of medical treatment in the country concerned. If the information is not readily available, an information request should be submitted to the COI Service (COIS). "

The Appellant's Evidence

10. The Appellant adopted three witness statements (dated 29 January 2015, 4 April 2016 and 15 May 2017) as evidence-in-chief. Her evidence can be summarised.
11. The Appellant came here in 1976 as a student and whilst in the UK she married her husband and her son, DB, was born here in 1981. He is a British citizenship. The Appellant had family in Nigeria and the family returned there in 1981. She came back to the UK as a visitor in 2003 and returned before the expiry of her visa. She came here again in January 2005 to see DB. It was during that visit that the Appellant became ill and she was diagnosed with a heart condition.
12. In 2006 or 2007 she was told she had an enlarged heart and she would have to go for tests. The Appellant was prescribed warfarin (she is allergic to aspirin and unfortunately, this medication is destroying her kidneys and she now has chronic kidney disease).
13. In 2007 the Appellant was admitted to hospital for several months and she was told that she would have an ICD implanted. She had the operation in 2009. Because of the dangers of warfarin, the Appellant must have weekly blood tests. She has a home monitoring machine which, if necessary, sends signals to the Royal Brompton

& Harefield Hospital who call for an ambulance should this be necessary. She has been taken to Royal Brompton & Harefield Hospital on two occasions (2015 witness statement).

14. The ICD device is under regular review. The Appellant's condition improved after the first year after it was implanted, but the symptoms of palpitations, tiredness, breathlessness started to return. She has been told that she is at risk of having a heart attack (she had a minor heart attack in 2007). She thinks the next appointment to monitor the ICD is in August 2017. She has three monthly check-ups with the Consultant and her warfarin is checked weekly. The Appellant suffers from asthma and uses two inhalers. She has swelling in her neck and pains in her knee. She uses a walking stick and attends physiotherapy.
15. The Appellant cannot travel on a flight to Nigeria as this would affect her heart and she would be concerned that she would have a heart attack. The Appellant would not be able to travel to Nigeria or live in Nigeria because of her health problems. The treatment which she presently receives in the UK would not be available to her in Nigeria. There are no adequate medical facilities in Nigeria. Her device would not be monitored and there are inadequate ambulance services. Nigeria is not equipped to take care of her medical issues. There are many fake drugs in Nigeria and there is no constant source of electricity. The Appellant is unable to work or run a business and would not be able to look after herself.
16. The Appellant does not have any property and has no income in Nigeria. She does not have a support network available to her. Her parents are deceased. Her mother passed away in 1997 and her father passed away in 2011. Her siblings and cousin are in the USA. She has no contact with her husband and does not know where he is. Her husband did not like her to have friends so she did not have any in Nigeria and he would stop her from seeing friends. She is supported by friends and family here but they would not be able to support her in Nigeria. Whatever they give her would not amount to much because the cost of living is higher there.
17. Prior to March 2016 the Appellant and DB were living together. The Appellant gave a few addresses where she has lived since 2005. DB has been studying in Manchester since 2013 and when they were living together he had to attend college three days a week. Whilst DB was in Manchester she was looked after by LB (her son's friend) and other friends who would come to the house to help her. The Appellant and DB had to leave their former home in Luton in March 2016 because the landlord sold the property. DB went to live in Manchester in order to complete his studies there whilst the Appellant moved in to live with a friend, CS, in Luton who is taking care of her now. DB is living separately from her, but this is a temporary arrangement. The Appellant sees DB weekly and they are in contact every day.
18. DB was not studying when she arrived in the UK, but after some time he commenced studies at the University of Kent. She has been supported since she has been here by friends, family and DB who was able to work during holiday periods. DB has

always paid the rent. She thinks that he has been funded by a Government scheme throughout his studies and he is now funding the course that he is doing.

19. The Appellant is aware of having received a bill in relation to NHS care and DB will repay that once he is in employment. He starts a job at the end of the month, but he is not currently working because he is at university. She was not able to give details of her son's future employers. He has been to India where he has been working on a placement. The Appellant cannot remember the last time DB went back to Nigeria. He did not travel there last year or the year before.

The Evidence of DB

20. DB's evidence is contained in his witness statements of 26 January 2015 and 15 May 2017, both of which he adopted as his evidence-in-chief. The evidence can be summarised.
21. DB's evidence before the First-tier Tribunal was that he lived with his mother and has been her main carer. His evidence was that he cooks, cleans and takes care of her, including taking her to appointments. His evidence was that he made arrangements for his friend, LB, or other friends and family to take care of her and that he has accommodated his mother at his home for approximately nine years. However, his evidence now is that this is no longer the case. His mother is now living with a friend in Luton and he is in Manchester where he is studying.
22. DB is studying a BA Hons in Creative Media and Visual Communication at Manchester Metropolitan University. He commenced his studies in September 2013 and graduates this year at the end of May. For the first two years whilst he was studying he had to be in Manchester for three days a week and he lived with his mother the rest of the time. Whilst he was in Manchester his friend LB would take care of her. His mother moved in with CS in March 2016 and he moved to Manchester. DB has a job starting at the end of the month and a permanent job starting in July 2017 in Media Production. Although this is subject to him successfully completing his BA, he is expected to do so. He will to repay his mother's NHS debt once he starts working.
23. DB gave up his studies at the University of Kent because of his mother's health condition. He was studying when she came here in 2005 but withdrew from the course in 2009. He had a student loan to fund his studies at the University of Kent.
24. In 2009 he was working as a musician. The group was based in Nigeria and he would go there to perform between 2010 and 2012. He was not studying during this period and he would go to Nigeria, usually during a festive period. The longest period he stayed there was for a month-and-a-half, but it was usually less than that.
25. DB has lost contact with his father. When he returned to Nigeria he did not attempt to contact him or to locate him. He did not see any of his parents' friends or

members of his family during his visits. In his absence, his friend, LB, and other members of the family looked after his mother.

26. DB's current studies are funded by a student loan and he works part-time. He owes in the region of £20,000 because of his studies. He has always paid his mother's rent. He received money towards the rent from LB who lived with him and his mother before March 2016.
27. DB would not be able to support his mother in Nigeria and neither could the aunts, uncles and other family members here. It would be difficult for her to take possession of any money sent to Nigeria. He does not know whether his mother was working in Nigeria prior to her coming to the UK and he does not know with whom she was living.

The Evidence of CS

28. CS's evidence is contained in her witness statements of 26 January 2015 and 15 May 2017 which she adopted as her evidence-in-chief. Her evidence can be summarised.
29. CS is a British citizen and has known the Appellant since 1983. The Appellant is like a sister to her. She moved in to live with CS in March 2016. This is a temporary arrangement until her son finishes at university when she will move back with him. The Appellant lives with CS and her four children and two grandchildren and they all help in looking after her. CS cooks for the Appellant, does her laundry, takes her to and from hospital appointments and helps her with anything she needs doing. She does not charge her rent. The Appellant cannot stand for long. She cannot carry her food to the table or lift anything heavy. Sometimes she needs help to put on her socks. CS does not think the Appellant could survive without her help which CS will continue to give even when the Appellant moves back to live with her son, DB.
30. In oral evidence CS stated that her house is very full and the Applicant shares a bedroom with CS's granddaughter who is aged 6. CS travels every year or so to Nigeria and has when there tried to look for the Appellant's husband so that he can help support her. It is a sensitive issue and she has not told the Appellant this.

The Evidence of PT

31. PT's evidence is contained in his witness statement of 3 May 2017 and can be summarised. He is fully aware of the Appellant's health condition and the network of friends and family that she has who rally around her to give her son, DB, help as he is at a crucial time as far as his studies are concerned. PT has been driving her to and from hospital appointments whenever the need arises when neither DB nor LB are available to help. The Appellant no longer has family ties in Nigeria. PT refers to the Nigerian President having to travel to the UK to receive medical treatment and care for problems that are not as serious as heart disease.

The Evidence of LB

32. LB's evidence is contained in his witness statement of 26 January 2015 and can be summarised. He is an Irish national and he has known the Appellant for around five years and is a good friend of her son, DB. They live together. The Appellant is like a second mother and they are close. DB is the main person who cares for her but LB looks after her when necessary and he is more than happy to do so. He takes her food when she is too unwell to get out of bed and he accompanies her to doctors' appointments.

Submissions

33. The Respondent's case is that there is no evidence that ICD devices are unavailable in the whole of Nigeria and the burden of proof rests on the Appellant. There is nothing before the Tribunal by way of recent medical reports that specifically state that the Appellant would be unable to travel to Nigeria by plane. There may be references to it being inadvisable but nothing that suggests it would be impossible or life-threatening. There is nothing to show that removal of the Appellant from the UK will lead to a breach of Article 3 and there is nothing to show that the Appellant is dying or close to death. The Respondent relies on N [2005] UKHL 31 (affirmed by ECHR in N v UK [2008] 47 EHRR 3931) and GS (India) & Ors v SSHD [2015] EWCA Civ 40. It is argued that these are domestic authorities that remain good law and reference is made to Lord Justice Laws in GS confirming the very high threshold required under Article 3 stating that in the "exceptional" class of case referred to in the authorities is "confined to deathbed cases" (paragraph 66).
34. In respect of Paposhvili v Belgium (Application No 41738/10, 13 December 2016) ("P"). The judgment is not binding on the UK courts, but in any event, the Applicant in that case died during litigation suggesting that his case may well have fallen within the exceptional class of case envisaged. The court emphasised in P that it is not an obligation for the returning state to alleviate the disparities between healthcare systems and it restates the key principles applicable in these cases. The decision in P turned on the fact that the Belgium authorities had failed to carry out any assessment of the risk facing the applicant in light of the information concerning his state of health and the existence of appropriate treatment in Georgia (see paragraph 205). The Respondent submits that this is not the case in this appeal because an assessment has indeed been carried out.
35. There is no medical document which makes reference to DB being a carer. There is nothing preventing support to continue from overseas through remittances and contact via the modern means of communication. The ongoing treatment the Appellant is receiving is at public expense and this should be weighed against her in the assessment of proportionality.
36. The Appellant's skeleton argument relies on P which, it is advanced clarified the correct approach where an Article 3 claim is argued on medical grounds. The

approach in N v UK that death must be imminent or in case BA, a very exceptional one, was reaffirmed in P and the court went on to provide guidance on the meaning of “very exceptional” at paragraph 183. The court also set out principles that apply in these kinds of cases. P is a judgment of the ECtHR. It does not legally bind the Tribunal; however, the Tribunal is required by Section 2(1)(a) of the Human Rights Act 1998 to take it into account. There is good reason for treating it as highly persuasive and is consistent with domestic jurisprudence. The court provided guidance as to the meaning of other very exceptional cases and approved the judgment in N.

37. The Appellant’s evidence establishes that there are substantial grounds to believe that if she is removed to Nigeria she would be exposed to a serious, rapid and irreversible decline in her health, leading to intensive suffering or to a significant reduction in life expectancy. In respect of flying the Appellant relies on the letter from Dr Travill dated 19 November 2014 the letter “To Whom It May Concern” from Lea Valley Medical Group dated 27 August 2014 and the letter from Dr Merinopoulos of 18 June 2015.
38. Reliance is also placed on the letter from the Federal Medical Centre of 12 September 2014 and the extract from a research paper summarising the widespread problem of fake drugs in Nigeria. In addition, reference is made to the article from www.howafrica.com mentioning the absence of defibrillators and an effective first responder service in Nigeria.
39. Ms Ravill referred me to the OGN of 2013. Neither party had a copy of this, but her submission was that it is clear from the document that the position has not changed since the Danish Fact Finding Mission report in 2008. The Appellant has established any evidential burden that is on her in accordance with P and the burden then shifts to the Respondent to show that sufficient medical treatment is available to the Appellant in Nigeria to prevent a breach of Article 3 and that she will be able to access it in practice. The Respondent has failed to discharge this burden by failing to adduce evidence of whether the Appellant’s condition can be effectively treated and her ICD supported in Nigeria, or if whether the risks from the long-haul flight can be eliminated. The necessary treatment includes medication, monitoring of the Appellant’s ICD and regular check-ups for the rest of her life. Even if the appropriate treatment exists in Nigeria it is doubtful whether the Appellant could afford to pay for it given her age, her inability to work and the absence of family support in Nigeria. The Respondent has not obtained assurances from the Nigerian state.
40. In relation to Article 8 reliance is placed upon the case of MM (Lebanon) & Ors v SSHD [2017] UKSC 10 in that the provisions of the Immigration Rules are only the starting point for consideration under the Convention. The Appellant relies on paragraph 276ADE(1)(vi) and the SSHD v Kamara [2016] EWCA Civ 813, Sales LJ at paragraph 14.

41. It is possible for a claim regarding medical treatment to succeed under Article 8 even when it would not do so under Article 3 and reliance is placed on MM (Zimbabwe) v SSHD [2012] EWCA Civ 279 which was endorsed by the Court of Appeal in GS (India). Respect to family life, the case of Singh & Anor v SSHD [2015] EWCA Civ 74 is relied upon.
42. The Appellant enjoys a private life in the UK and family life with her son who cares for her and supports her financially, practically and emotionally, and has done for more than twelve years. There would be an interference with her family/private life. There are very significant obstacles to the Appellant's integration into Nigeria because of the absence and unaffordability of appropriate treatment, the absence of support for her ICD, the lack of family in Nigeria to provide emotional and practical support, the Appellant's inability to work in order to support herself financially, the absence of accommodation available to her on return, her limited mobility, which would restrict her ability to access medical treatment and to participate in society and the risks to her health of flying to Nigeria.
43. In the alternative the Appellant's removal would be disproportionate. The extent of her emotional and practical dependency on others and the severity of her medical condition and the complex and sophisticated nature of her treatment lend her private life a special compelling character that justifies departure from the normative guidance in Section 117B (4) and (5) (Rhuppiah v SSHD [2016] EWCA Civ 803). Great weight should be attached to the Appellant's family life with her son and the relationship could not be replicated in Nigeria because the Appellant has no family there and would be isolated. The quality of her life would be seriously diminished without her son's presence. The Appellant is not financially independent but she is fully supported by friends and family and is therefore unlikely to become a burden on public funds.

P

44. The salient paragraphs of P are as follows: -

“183. The Court considers that the ‘other very exceptional cases’ within the meaning of the judgment in *N. v. the United Kingdom* (§ 43) which may raise an issue under Article 3 should be understood to refer to situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy. The Court points out that these situations correspond to a high threshold for the application of Article 3 of the Convention in cases concerning the removal of aliens suffering from serious illness.

184. As to whether the above conditions are satisfied in a given situation, the Court observes that in cases involving the expulsion of aliens, the Court does not itself examine the applications for international protection or verify how States control the entry, residence and expulsion of aliens. By virtue of Article 1 of the Convention the primary responsibility for implementing and enforcing the guaranteed rights and freedoms is laid on the national authorities, who are thus required to examine the applicants' fears and to assess the risks they would face if removed to the receiving country, from the standpoint of Article 3. The machinery of complaint to the Court is subsidiary to national systems safeguarding human rights. This subsidiary character is articulated in Article 13 and Article 35 § 1 of the Convention (see *M.S.S. v. Belgium and Greece*, cited above, §§ 286-87, and *F.G. v. Sweden*, cited above, §§ 117-18).
185. Accordingly, in cases of this kind, the authorities' obligation under Article 3 to protect the integrity of the persons concerned is fulfilled primarily through appropriate procedures allowing such examination to be carried out (see, *mutatis mutandis*, *El-Masri v. the former Yugoslav Republic of Macedonia* [GC], no. 39630/09, § 182, ECHR 2012; *Tarakhel*, cited above, § 104; and *F.G. v. Sweden*, cited above, § 117).
186. In the context of these procedures, it is for the applicants to 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 (see *Saadi*, cited above, § 129, and *F.G. v. Sweden*, cited above, § 120). In this connection it should be observed that a certain degree of speculation is inherent in the preventive purpose of Article 3 and that it is not a matter of requiring the persons concerned to provide clear proof of their claim that they would be exposed to proscribed treatment (see, in particular, *Trabelsi v. Belgium*, no. 140/10, § 130, ECHR 2014 (extracts)).
187. Where such evidence is adduced, it is for the authorities of the returning State, in the context of domestic procedures, to dispel any doubts raised by it (see *Saadi*, cited above, § 129, and *F.G. v. Sweden*, cited above, § 120). The risk alleged must be subjected to close scrutiny (see *Saadi*, cited above, § 128; *Sufi and Elmi v. the United Kingdom*, nos. 8319/07 and 11449/07, § 214, 28 June 2011; *Hirsi Jamaa and Others*, cited above, § 116; and *Tarakhel*, cited above, § 104) in the course of which the authorities in the returning State must consider the foreseeable consequences of removal for the individual concerned in the receiving State, in the light of the general situation there and the individual's personal circumstances (see *Vilvarajah and Others*, cited above, § 108; *El-Masri*, cited above, § 213; and *Tarakhel*, cited above, § 105). The

assessment of the risk as defined above (see paragraphs 183-84) must therefore take into consideration general sources such as reports of the World Health Organisation or of reputable non-governmental organisations and the medical certificates concerning the person in question.

188. As the Court has observed above (see paragraph 173), what is in issue here is the negative obligation not to expose persons to a risk of ill-treatment proscribed by Article 3. It follows that the impact of removal on the person concerned must be assessed by comparing his or her state of health prior to removal and how it would evolve after transfer to the receiving State.
189. As regards the factors to be taken into consideration, the authorities in the returning State must verify on a case-by-case basis whether the care generally available in the receiving State is sufficient and appropriate in practice for the treatment of the applicant's illness so as to prevent him or her being exposed to treatment contrary to Article 3 (see paragraph 183 above). The benchmark is not the level of care existing in the returning State; it is not a question of ascertaining whether the care in the receiving State would be equivalent or inferior to that provided by the health-care system in the returning State. Nor is it possible to derive from Article 3 a right to receive specific treatment in the receiving State which is not available to the rest of the population.
190. The authorities must also consider the extent to which the individual in question will actually have access to this care and these facilities in the receiving State. The Court observes in that regard that it has previously questioned the accessibility of care (see *Aswat*, cited above, § 55, and *Tatar*, cited above, §§ 47-49) and referred to the need to consider the cost of medication and treatment, the existence of a social and family network, and the distance to be travelled in order to have access to the required care (see *Karagoz v. France* (dec.), no. 47531/99, 15 November 2001; *N. v. the United Kingdom*, cited above, §§ 34-41, and the references cited therein; and *E.O. v. Italy* (dec.), cited above).
191. Where, after the relevant information has been examined, serious doubts persist regarding the impact of removal on the persons concerned – on account of the general situation in the receiving country and/or their individual situation – the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the persons concerned so that they do not find themselves in a situation contrary to Article 3 (on the subject of individual assurances, see *Tarakhel*, cited above, § 120)."

Findings and Reasons

45. I did not find that the Appellant, DB or CS were credible about the Appellant's connections in Nigeria. I find that there were aspects of their evidence that was exaggerated and they have not been candid. The Appellant's evidence was that she had noone left in Nigeria and that she has not seen her husband since she left and he has effectively abandoned her. However, her evidence and that of DB was wholly lacking in detail about this significant event. I found it lacking in credibility that both the Appellant and her son have not attempted to locate him and again on this issue the evidence was vague. The general tenor of the evidence is that the husband and father abandoned his family, but the evidence is more in keeping with a disappearance. However, there was no evidence that the Appellant or DB had attempted to contact members of his family to locate him. There was no evidence of a marriage breakdown leading up to abandonment. The Appellant failed to provide a sufficiently detailed and clear account of what had happened. I find that DB was vague about with whom his mother lived before she came here and contact with his father generally.
46. On the second day of the hearing CS gave evidence about how she had attempted to locate the Appellant's husband, but I am sceptical about this. I realise that the issue may understandably be sensitive and difficult to raise with the Appellant, but it is not credible that CS would not only fail to disclose this information to the Appellant at the time, but has continued to do so until giving evidence at the hearing on 21 June, as she claimed. There is no reference to it in her witness statement of 15 May 2017. I conclude, considering the evidence in the round that CS was trying to fill in the obvious gap in the Appellant's evidence which was exposed in cross examination.
47. DB in his statement made no reference to having returned to Nigeria and the Appellant stated that she could not remember DB having returned to Nigeria. However, when he was cross-examined, it became clear that he had returned to Nigeria on several occasions between 2009 and 2013 to perform music. In my view, the Appellant intentionally failed to provide this evidence to the Tribunal to attempt to distance herself from connections there and DB had intentionally failed to mention it in his witness statement for the same reasons. I reach the unavoidable conclusion that DB and the Appellant have family in Nigeria including the Appellant's husband and connections generally.
48. The evidence was at best vague in relation to funds. The Appellant's evidence is that she relies on her son, friends and family here and abroad (she has siblings in the USA). DB's evidence was ambiguous because it is not sufficiently explained how he has been able to look after himself and his mother since she came here. He has a debt of £20,000 from his studies here. There was very little evidence of employment and it seems that he has mainly been a student since her arrival. The Appellant is now accommodated by CS and CS's evidence is that she sometimes helps the Appellant buy medication. The Appellant has been here 12 years and there is no cogent

evidence before me which would explain how she has managed to maintain herself throughout this period. In the light of the insufficient and generally vague evidence in respect of funding and contacts in Nigeria, the reasonable inference to be drawn is that the Appellant's family in Nigeria, is at least in part, supporting her financially and could continue to do so. I do not accept PT's assertion that the Appellant does not have family in Nigeria. He may well believe this to be the case, but considering the evidence as a whole, I do not find this statement accurately reflects the position. He did not give oral evidence.

49. The Appellant and her son do not live together. The evidence of LB represents the situation in 2015. I accept that BD and the Appellant have lived together lived together, but he is not and has not been her primary carer. When they were living together, he spent a considerable period of time in Manchester, whilst she remained in Luton. There was a third person living in the house, LB, who would help the Appellant. In my view, it is more likely that the present living arrangement has come about because DB wished to continue his studies and live independently in the knowledge that his mother could rely on a number of people to help her. He is only one part of the network that is available to her here. I find that it is more likely than not that the Appellant moved in to live with CS because she has nowhere else to live whilst here and not because she needs someone to care for her. I accept that CS helps the Appellant, as do others, but I do not accept that the Appellant needs a "carer" and that she could not live independently with some reliance on friends and or family for lifts to the hospital and certain household chores. I was not referred to any medical evidence to support the need for a live in carer.
50. Whilst I do not doubt that DB is employable and has been offered work in completion of his course, I do not accept that the evidence establishes that it is reasonably likely that he and his mother will resume living together. I accept that they are close and see each other often, but they have not lived together since March 2016. The evidence does not show financial dependency or that the Appellant depends on DB to care for her. I have considered the evidence in BD's witness statement of 26 January 2015, in which he asserts that he is his mother's primary carer, but this evidence was an exaggeration, considering that he did not live with his mother all week, but spent at that time part of the week in Manchester. In addition there was evidence before me of DB travelling to Nigeria and India. The Appellant and BD have embellished their evidence about their relationship and the level of dependency and care given by DB. However, I accept that the Appellant is vulnerable because of health problems. I accept that the Appellant has some mobility issues and relies to some extent on family (at times her son) generally to help her, but I do not accept that her every day care needs are such that she cannot live independently. She has failed to establish that she would not have the level of care she requires from family and friends in Nigeria. I have taken into account all of the evidence from friends and family in the AB.

Article 3

51. I accept Ms Revill's submission there is good reason for treating P as highly persuasive and, in any event, it is consistent with N [2005] UKHL 31 (affirmed by ECHR in N v UK [2008] 47 EHRR 3931), in so far as it seeks to explain the "other very exceptional cases."
52. Ms Revill submitted that the Appellant has adduced evidence capable of demonstrating that there are substantial grounds for believing that removal would expose her to risk, but I do not accept this. If P establishes that there is an evidential burden of any kind on the Appellant (which once discharged shifts to the Respondent), this has not been discharged; notwithstanding, a certain degree of inherent speculation.
53. The Appellant suffers from serious health conditions. She has non-ischaemic dilated cardiomyopathy, chronic kidney disease, asthma and musculoskeletal problems. She has been fitted with an implantable cardiac defibrillator (ICD) which kick-starts her heart and which is connected to a home monitor and provides daily online updates as to her condition. It is beyond doubt that she receives a considerable amount of treatment and monitoring whilst she is here. She sees a consultant cardiologist at least every three months and her ICD is monitored. The evidence before me does not establish that there has been any significant deterioration in the Appellant's condition and her condition is monitored and her condition stable. It is not the Appellant's case that she is at imminent risk of dying should she be removed, but that her case is an exceptional case.
54. In respect of a risk arising from flying, the most up-to-date evidence relied on is the letter of 18 June 2015 from Dr I Merinopoulos in which he gives an account of Dr Travill's opinion. Dr Travill is the Appellant's consultant and he strongly advises against travel. Set out in this letter is the worst-case scenario and the conclusions are conditional on the absence of appropriate facilities to manage the Appellant's ICD and the possibility of the device not being able to be monitored in Nigeria. The doctor is also concerned about unexpected problems and the absence of medical expertise. From the correspondence, it is clear that Dr Travill is not concerned with risk on a long-haul flight to Nigeria, but he is giving his opinion about the possibility of the lack of facilities and medical care in Nigeria.
55. The evidence from Dr George (Lea Vale Medical Group) is almost three years out of date and, in any event, the assertion that the Appellant would be "unsuitable..... to take long distance travel and especially air travel" is inadequately expanded upon and does not go close to establishing an Article 3 risk. The Appellant relies on a letter from Dr Kumar of 7 August 2008, which reflects the position almost a decade ago and before the ICD was fitted. This states that the Appellant is at "higher risk of developing symptomatic heart failure at high altitude," but goes on to state that if the journey is essential and unavoidable she would recommend that she informs the details of her illness to the flight authorities so that if necessary she might be able to

get some oxygen supplements.” I have considered the evidence produced by the Respondent which, on the face of it, establishes that the 33,000 patients with ICDs are not at risk per se as a result of the ICD but the nature and stability of the underlying condition (in the Appellant’s case cardiomyopathy) requires careful consideration and may be of greater significance than the presence of the device, although it is noted that the majority of patients with an implanted device may travel safely. There is no evidence to suggest that the Appellant’s condition is not stable. Taking all of this into account, the Appellant has not adduced evidence capable of demonstrating a risk under Article 3.

56. Once returned to Nigeria it is beyond doubt that there will be a change in the Appellant’s treatment and it is certain that the treatment she will receive in Nigeria will be inferior to that which is available to her here. However, whilst I appreciate that it is very disappointing that the Respondent has failed to produce up to date evidence, the evidence produced by the Appellant is woefully out of date and inadequate. It may well have been the case that in 2008 that treatment was inadequate, but this evidence is almost a decade out of date. Ms Revill argues the position has not changed and seeks to rely on the 2013 OGN. This is four years out of date; however, I do not accept that the reference to a COI, establishes that it is reasonably likely that the 2013 report is confirming the position in the 2008 Danish Immigration Service Report. The argument is tenuous. The interview with a Nigerian US based cardiologist is undated and ambiguous. The letter from Dr Ndom relates to one hospital in Nasarawa state. The evidence has little if any evidential value in terms of what treatment is available in 2017.
57. The background evidence is out of date and inadequate not capable of demonstrating that there are substantial grounds for believing that there is no treatment available in Nigeria to treat the Appellant’s condition. In respect of access to treatment, if it is available only at a cost, having found it reasonably likely that the Appellant has a source of income from Nigeria, and in the light of her evidence of support from family and friends here (which could continue), she has not established that treatment would not be available to her. BD’s evidence is that he has employment here to commence after the completion of his course. His evidence was that he would then repay the debt to the NHS. He is not liable for the debt as it was incurred by his mother and he could use his salary instead to support his mother’s treatment in Nigeria. I accept that whilst in the UK the Appellant depends on a certain level of help in the home and to get to appointments. Having found that it is reasonably likely that the Appellant has a support network in Nigeria, this will facilitate access to treatment. Whilst I accept that there may be a problem (or at least there was in 2007 -2008 which is the date of the evidence relied on by the Appellant) with fake drugs in Nigeria, the evidence does not establish that in 2017 the problem is such as to put the Appellant at risk.
58. The Appellant has wholly failed to produce any relevant up to date evidence relating to the availability and access to treatment in Nigeria capable of demonstrating risk under Article 3. The Appellant has not established that she faces a real risk, because

of the absence of appropriate treatment in Nigeria or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in her state of health resulting in intense suffering or to a significant reduction in life expectancy. For all the above reasons the appeal is dismissed on Article 3 grounds.

Article 8

59. The Appellant has not established that there would be very significant obstacles to integration. Having considered the judgement in Kamara [2016] EWCA Civ 813 regarding very significant obstacles I take account what LJ Sales stated at para 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”.

60. The Appellant has been here for 12 years. I conclude that she has a support network in Nigeria. Her son returned there as recently as 2013 and her close friend CS makes annual visits there. I do not accept her evidence in respect of her husband or lack of contacts in Nigeria generally. There is no evidence that she would be an outsider there. Whilst she has a number of health problems, they would not prevent her from having a private life there where treatment will be available to her and she will be able to access it. The Respondent does not accept that there are very significant obstacles, but in any event, relies on paragraph 322 (12) of the Rules, in respect of the outstanding debt to the NHS. The Respondent asserts that the Appellant fails to meet the suitability requirements of the Rules for the same reason. Whilst the Appellant falls for refusal under the suitability rules, it is not material because she does not meet the requirements of 276ADE (1) (vi) in any event. The Respondent has not exercised discretion under para 322 (12) and I make no decision in relation to this. It is not material to the outcome in this case. It is a matter for the Respondent should she wish to make a decision under para 322 (12).
61. The Appellant and her son have not been straight forward and are not credible concerning parts of their evidence. However, there is an element of dependency over and above the normal ties between mother and adult child, but not close to the extent claimed by the Appellant. The Appellant has a family and private life here and the decision interferes with it. The decision ultimately turns on proportionality. The

maintenance of effective immigration control is in the public interest. This Appellant is an overstayer and, whilst I sympathise with her, she is nevertheless a burden on taxpayers.

62. In terms of the weight to be given to her private life, I have considered that she has been in very poor health since she arrived here and I have attached more than a little weight to her private life, but I also attach weight to the fact that she is an overstayer. It is material to the proportionality assessment that she will receive inferior treatment when in Nigeria and life generally will be more difficult for her; however, she has failed to produce cogent evidence which establishes the level of care in Nigeria and how it would compare to that she now receives and the implications of this. However, I accept it will not be to the standard she has become accustomed to here.
63. The Appellant is a lady with significant health problems with a degree of vulnerability because, to a certain extent, she is reliant on friends and family here. Removal will be difficult and distressing for both the Appellant and her son and I have attached significant weight to the interference to their relationship, but I reject that she is as dependant on him as claimed. They have a close relationship and he helps her when he is in Luton, but they do not live together. I do not accept that this is only temporary. It is clear from the evidence that CS and BD are mobile and travel to Nigeria. The Appellant will not be wholly isolated from her friends and family here. As an overstayer she has benefited from having a pacemaker fitted and medical treatment here over the 12 year period that she has been here. Significantly in this case I have rejected the evidence in respect of the life she will return to in Nigeria in terms of health care and family support available to her. I find that treatment is available and she will have access to it. The decision will interfere with her family life with her son, but I find that she has family in Nigeria with whom family life can be resumed. Removal is in the public interest. The scales tip in favour of the Respondent and I conclude that removal is proportionate.

Application to Admit Post Hearing Evidence

64. A day after the hearing, when I indicated that I would reserve my decision, Mr Melvin forwarded to the UT, for my attention, a letter detailing unsuccessful applications made by members of the Appellant's family. There is evidence, according to the Respondent, that the Appellant entered the UK in 2005 with two other sons (two more sons made applications at this time and they were refused) and their human rights application was refused in 2008; however, they remained here without leave. One of them made a human rights claim which was certified in 2016. He has since made further representations which are under consideration. The other son made an asylum claim which is under consideration. The Appellant's husband entered the UK as a visitor in 2007 and was arrested for driving offences in 2008. Nothing was heard from him until he made an application for a visit visa in 2014 which was refused. The Respondent seeks to admit this evidence.

65. It is astounding that the Respondent has not produced this evidence earlier considering there have been to date three appeal hearings and it has always been an issue whether the Appellant has connections in Nigeria. There is no good reason advanced that explains why this evidence was not served in a timely fashion giving the Appellant the opportunity to engage with it. The hearing has now concluded and I refuse the application. The evidence is not admitted and I have had no regard to it.

Notice of Decision

65. The appeal is dismissed under Article 3 and Article 8.

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 her or any member of her 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 *Joanna McWilliam*

Date 23 June 2017

Upper Tribunal Judge McWilliam