



IN THE UPPER TRIBUNAL
IMMIGRATION AND ASYLUM CHAMBER

Case No: UI-2022-002095

First-tier Tribunal No: PA/01104/2021

THE IMMIGRATION ACTS

**Decision & Reasons Issued:
On 18 August 2023**

Before

UPPER TRIBUNAL JUDGE HANSON

Between

**SB
(ANONYMITY ORDER MADE)**

Appellant

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr C Holmes, instructed by the Manuel Bravo Project.
For the Respondent: Ms Z Young, a Senior Home Office Presenting Officer.

Heard at Phoenix House (Bradford) on 24 July 2023

Order Regarding Anonymity

Pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008, [the appellant] (and/or any member of his family, expert, witness or other person the Tribunal considers should not be identified) is granted anonymity.

No-one shall publish or reveal any information, including the name or address of the appellant, likely to lead members of the public to identify the appellant (and/or other person). Failure to comply with this order could amount to a contempt of court.

DECISION AND REASONS

1. Following a hearing at Bradford on 20 February 2023 the Upper Tribunal found an error of law material to the decision of the First-tier Tribunal judge who dismissed the appellant's appeal.
2. Although the majority of the findings made by the First-tier Tribunal were found not to reveal legal error, let alone material legal error, the challenge to the decision based on the procedural aspects of Article 3 in light of the appellant's

mental health, not necessarily the substantive question, was conceded as not having been dealt with, by the Senior Presenting Officer in attendance.

3. The specific legal error is that set out at [6(a)] of the grounds seeking permission to appeal in which it is written:
 - a) Judge Brooks misdirected himself in relation to Paposhvilli. Dr Millers medical report clearly states that the Appellant would suffer from and severe and rapid decline in her mental health by virtue of being removed. It is therefore submitted that the Appellant would not be in any fit state to access medical treatment, not that medical treatment will be immediately available to her on arrival in Nigeria anyway, nor could she afford it.
4. The findings of the First-tier Tribunal dismissing the appellant's protection claim shall be preserved as shall the findings of the availability of emotional support from the appellant's brother in Nigeria, her immigration history, her family composition, the diagnosis of health issues, and the availability of treatment in Nigeria as found by Judge Brooks.

The medical evidence

5. The appellant has provided updated medical evidence in accordance with the directions given.
6. An updated GP consultation dated 20 April 2023, with a Dr Joanne Miller, shows the reported problems as being depressed mood, PTSD with some symptoms not comprehensively diagnosed, and suicidal thoughts. GP records show a history of crisis prevention around asylum difficulties which have usually needed sedatives and monitoring to settle the appellant while they allow the situation to settle, and that the crisis has been triggered again by asylum related news that the appellant had been informed by her solicitors that most of her appeal rights have come to an end and the only remaining issue comes down to her mental health and stability. The plan is for the provision of sedatives for sleep and to calm the appellant down.
7. Dr Miller has provided a letter dated 28 April 2023 to the appellant's representatives, the Manuel Bravo Project, in response to a specific request having been made on 18 April 2023. The letter sets out a number of questions that Dr Miller was asked and her response to the same in the following terms:

You have asked me to address the following issues:

1. What diagnosis if any they have received;

Please refer to last letter 9/9/2021(attached) as there has been no change.

2. What if any changes have happened since their last letter?

The pattern of her health difficulties has remained the same. She has periods when she copes relatively well, punctuated with crises. These usually relate to asylum related difficulties or frustrations about her situation. We had to deal with crises on 17/11/2021, 21/3/2022, 10/11/2022 and 20/4/2023. In 3 instances we prescribed sedatives.

3. What treatment do they currently receive;

Sertraline 150mg daily which is an anti-depressant. Has been referred to Solace for therapy.

4. What if any affect would pausing this treatment temporarily have on them?;

It would depend on the context. If the medication was paused at this point in time, in her current context, I would expect her mood to lower.

5. What if any affect would stopping this treatment entirely have?;

Above it would depend on the context.

6. What would be the likely effect of removal to Nigeria on their health?

No change to answer 4 of previous letter.

7. Would they be in a position to access health treatment in Nigeria on return?

I do not know.

8. Any other relevant information they would like to bring to the Judge's attention.

I have some concerns about the ongoing impact of her mood on her children, especially the older child. When she is in a crisis she is unable to contain her distress and keep it from her children.

She has thoughts of ending her life because she is aware her children might be able to stay in the UK if she did this. She does not really want to die but sees it as an option. The main reason she has stated she is unlikely to do this is because her son 'copies' her behaviours and she is worried he could kill himself if she does. She told me if she cannot eat, he stops eating. I have spoken to her on the phone when she has been wailing and then I have heard her son wailing as well. I have concerns about how she may respond if she reaches a point when she realises she has no options left to remain in the UK.

...

Dr Joanne Miller MBChB (1997), MRCGP (2001) Diploma in examination of sexual assault, Manchester University 2008.

Signature

8. The original letter referred to by Dr Miller reads:

You have asked me to address the following issues:

1. SB's medical conditions are, including mental health

She has a diagnosis of depression and post-traumatic stress disorder (PTSD).

1. What medication and dose is she taking

Sertraline 100 mg daily. Often used in PTSD.

2. Any other therapy we are aware of?

Our records suggest she has had psychological therapy at times, but we do not usually receive reports about this, so I cannot tell you any more. It is very difficult to get therapy in our area, so if she is not currently accessing it, this is not because she does not need it.

3. How is her mental health condition being managed and what progress has she made as a result of this?

We manage her mental health on an as and when crisis basis. PTSD should be considered a chronic psychological condition which remits and relapses. When her life is relatively calm and there is no perceived threat to her safety SB settles down and is able to get on with her life. As soon as she perceives a threat to her safety she deteriorates into a state of acute distress with re-triggering of PTSD symptoms such as nightmares and intrusive memories. She struggles to function during these periods and will usually have to medicate her with diazepam (an acute medication to reduce anxiety and sedate). As the perceived risk recedes, she will recover again. This pattern of remission and relapse is all we can expect as a prognosis whilst her fear of being returned to Nigeria is present. This fear does not prevent significant lasting recovery. I would envisage a much better prognosis following therapy if this fear of return ends.

4. Whether removal to Nigeria would mean SB faced a real risk of being exposed to a serious, rapid, irreversible decline in their state of health, or significant reduction in life expectancy, as a result of mental health?

This is not an easy question to answer as it is context dependent and I do not know what situation she would face on return to Nigeria and whether this would be as bad as she states she fears. From my experience of working with her I can say that her mental state will deteriorate if she is returned to a situation in Nigeria where she is in danger because I have witnessed what happens to her when she believes she might be in danger. This deterioration tends to be severe and rapid. I can't comment on the reversibility as this would also be context dependent.

5. Would SB be at risk of suicide if she returned to Nigeria?

Again, this is context dependent. In the past she has talked about it being better to die than to be killed in Nigeria. More recently she has not expressed suicidal ideation. This does not mean her mental health has improved. It is more likely to be a result of being a parent. She has never expressed thoughts of harming the children in a crisis. Risk assessments must be repeated if there are negative developments in her situation.

6. In your opinion would it be safe to remove SB to Nigeria given her mental health needs?

I would not be able to give any assurance that it is safe to return her to Nigeria.

9. There is a reference in the letter to the appellant having been referred to Solace. Further information has been provided by them dated 19 April 2023 in the following terms:

To Whom It May Concern,

Re: Ms [S B] (DOB: 14/08/1980) Country of Origin: Nigeria

I am writing to provide an update on the mental health condition of Ms [SB], who has been receiving therapy at Solace Surviving Exile and Persecution, a mental health organization that offers therapeutic services to refugees and asylum seekers in Leeds, Huddersfield, and Halifax. I am Reza Nemati, a Lead Psychotherapist at Solace in Kirklees and Calderdale, and I have been working closely with [SB].

[SB] was referred to Solace by her GP practice, NHS Huddersfield, (Whitehouse Centre) on three occasions. The first referral was on 23/02/2019, and she was discharged on 25/02/2020 after making good progress in therapy. The second referral was on 22/07/2021, but due to our limitations in offering more than 12 sessions, the therapy could not continue. However, [SB] had reached a more stable

condition and was discharged on 09/03/2022. She was re-referred again on 24/02/2023 due to recurring symptoms of General Anxiety, Panic attacks, Depression, Difficulty in Sleep, nightmares, and daily flashbacks.

Based on the latest assessment conducted on 19/04/2023, [SB] is still suffering from symptoms of Post Traumatic Stress Disorder (PTSD) as a result of being a victim of domestic violence in her home country. She bears visible marks on her chest from the aggressive actions inflicted by her husband, who cheated on her while she was pregnant and injured her with a broken glass bottle. Her score of 71 on the Impact of Events Scale (IES), which measures the frequency and intensity of intrusive thoughts, avoidance behaviours, and hyper-arousal symptoms related to the traumatic event, shows an extremely high level of distress as a score of 71 out of a possible 88 indicates severe Post Traumatic Stress Disorder (PTSD). (A score of 33 and above indicates a probable PTSD diagnosis with a score of 37 plus indicating a mental health disorder strong enough to suppress one's immune system, even up to 10 years after the event. See <https://www.aerztenetz-grafschaft.de/download/IES-R-englisch-5-stufig.pdf>) thus [SB's] score of 71 suggests a high level of severity of PTSD and the need for professional help to manage her psychological distress. The CORE10 assessment also indicates a score of 31/40, emphasizing her "Severe" mental health condition overall.

[SB] has reported that her mental health condition has also affected her son, D, who is a smart boy and used to be successful at school and in sports activities. However, D has been crying at school, refusing to eat, and exhibiting symptoms of anxiety as a result of his mother's mental health condition and their instability as asylum seekers.

One of [SB] dominant fears is that she will be attacked by the Black Axe cultist group upon returning to her home country, as she had previously exposed them to the authorities when she was the vice-president of the students' union of Lagos State University in 2008/2009. Based on my professional observations and assessment of her psychological symptoms, I can confirm that [SB] is currently in a very vulnerable and fragile condition, and she requires long-term therapy to achieve a stable mental health condition. Any changes in her current circumstances that may bring further instability or distress, such as the risk of deportation, would likely act as triggers, causing her to recall the traumatic memories and perceive herself and her son as being in an insecure, unsupported, and unsafe condition once again. In my opinion, [SB]'s current mental health condition is in a critical stage, and it would be inhumane to remove her from the UK. Her removal would reach a high threshold of severity based on her medical condition, and it would prevent her from completing her therapy, potentially leading to an irreversible and detrimental impact on her mental health. When [SB] is in a place of safety, she is capable of managing her affairs and with on going therapy, she could recover from her mental health difficulties to thrive and make a positive contribution. She is an educated woman with leadership abilities as can be seen in her experience of vice president of the student union at Lagos University, however the impact of the violence she endured and the fear of returning to those same threatening conditions are overwhelming her ability to cope, making her even more vulnerable to the increase in such reliving experiences as nightmares, flashbacks and intrusive thoughts.

[SB] has been referred to the Solace Women's Wellbeing Group to help her maintain some emotional stability and self-regulation, however it is clear that she is in need of further psychotherapy to process her traumatic experiences, however while she is living with perpetual insecurity, she is not in a psychological space to do so as the ongoing fear will consistently undermine any progress.

I confirm that I have made clear which facts and matters referred to in this report are within my knowledge and which are not. Those that are within my knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

If you have any queries, please do not hesitate to contact me via my email: reza@solaceuk.org.uk.

Yours Faithfully, Reza Nemati, (MBPsS-356744) Solace Lead Psychotherapist,

Other evidence, discussion, and analysis

10. I have also seen a letter in support written by the Rev Amanda Ogilvy-Berry the Assistant Curate of Huddersfield Parish Church.
11. As noted above, concern is expressed in relation to the impact of the appellant's condition and reaction upon her son D. A letter has been provided from his Junior School dated 19 April 2023 confirming D receive some well-being support from a member of their Actual Team in November 2021, that SB is part of the school community and attends weekly well-being workshops and other parents groups in school to support her own and her children's well-being.
12. It is important to specifically consider the preserved findings which are relevant to some of the issues recorded in the medical information provided.
13. Judge Brooks in the determination promulgated on 7 November 2021 took as the starting point in accordance with the Devaseelan principles an earlier decision of 10 July 2019. The claim that had been made by the appellant on that occasion was that she feared returning to Nigeria due to her abusive ex partner and that her daughter will be subject to female genital mutilation (FGM). At [47] Judge Brooks refers to a specific finding made in the earlier determination in the following terms *"taking the above matters together I find the appellant's entire account unreliable and I find she is a liar whose evidence lacks credibility. I reject her claim to have had FGM. I reject her claim to fear her ex-partner and I find she and her children (son and daughter) face no real risk of serious harm if returned to Nigeria. I consider the evidence shows the appellant is reasonably likely to be an economic migrant who has sought to use the visa system to gain access to education, access to NHS medical services and a new life in the UK. The appellant is entirely capable of returning to Nigeria, and in particular, Lagos, where she can find new employment to support herself and her children"*.
14. The Judge noted the appellant relied upon the earlier medical report dated 9 September 2021 prepared by Dr Miller to which weight was placed, and it found the appellant has a diagnosis of depression and PTSD.
15. In relation to the appellant's claim to face a real risk from the Black Axe Cult, Judge Brooks wrote at [60]:

60. I do not find it reasonably likely to be true that the appellant is of interest to the Black Axe cult. The appellant left her position at LAUSU in 2009. The appellant then remained in Lagos until she came to the United Kingdom in October 2017. During this time the appellant lived and worked in Lagos. At no point during this eight year period did the appellant face any issues with the Blacks Axe cult. It is now some 12 years since the appellant was in post at LASUSU. Whilst the background evidence does suggest that cultist groups are active in educational establishments, the examples cited related to current students. In evidence the appellant stated that the Black Acts do not operate within a specific time and that they can strike at any time. However, I have not been directed towards any evidence to corroborate the appellant's claim that she would be of interest to them some 12 years later. Whilst I appreciate that it is not always possible for corroborative evidence to be provided, the background evidence does refer to cult activity on university campuses. If this was to continue several years after individuals had left University, I would expect this to also be recorded in the background evidence.
16. At [62] Judge Brooks wrote:

62. Considering all the evidence in the round, I am not satisfied that the appellant's account is reasonably likely to be true. Viewed as a whole, I reject the entirety of the appellant's account as credible. I find that there are several issues which undermine the appellant's credibility, even taking into account her status as a vulnerable witness. I find that these issues are significant. I do not accept that the appellant would be at risk on return from the Blacks Acts. I find that the appellant has not established the lower standard of proof that she faces a real risk of persecution or serious harm if returned to Nigeria.
17. The reference in the medical evidence to the appellant therefore fearing domestic violence and/or harm at the hands of the Black Axe cult has no merit, as two judges of the First-tier Tribunal have found the appellant lacks credibility, has lied, and that her claims in this respect are not true. The appellants claims are therefore not objectively substantiated.
18. These findings are very relevant. In the original letter dated 9 September 2021 Dr Miller wrote:

4. Whether removal to Nigeria would mean SB faced a real risk of being exposed to a serious, rapid, irreversible decline in their state of health, or significant reduction in life expectancy, as a result of mental health?

This is not an easy question to answer as it is context dependent and I do not know what situation she would face on return to Nigeria and whether this would be as bad as she states she fears. From my experience of working with her I can say that her mental state will deteriorate if she is returned to a situation in Nigeria where she is in danger because I have witnessed what happens to her when she believes she might be in danger. This deterioration tends to be severe and rapid. I can't comment on the reversibility as this would also be context dependent.

5. Would SB be at risk of suicide if she returned to Nigeria?

Again, this is context dependent. In the past she has talked about it being better to die than to be killed in Nigeria. More recently she has not expressed suicidal ideation. This does not mean her mental health has improved. It is more likely to be a result of being a parent. She has never expressed thoughts of harming the children in a crisis. Risk assessments must be repeated if there are negative developments in her situation.

19. It is accepted that the appellant does not wish to return to Nigeria and the uncertainty as to her future is of concern to her. That aspect of her immigration status is recognised as being a factor in her presentation and mental health needs as identified in particular by Dr Miller. Whilst the causation of such presentation is not as the appellant claims, as the domestic violence issues and threats from the Black Axe gang have been found to lack credibility, the context is of importance. Dr Miller specifically identifies it is relevant whether the situation facing the appellant on return to Nigeria would be as bad as she states she fears. The findings of the First-tier Tribunal show this will not be the case. It is stated the appellant's mental state will deteriorate if she is returned to a situation in Nigeria when she is in danger but there is no credible evidence that she will face any danger. Whilst there is likely to be an adverse reaction from a negative immigration tribunal decision it is not made out it would be irreversible or that treatment will not be made available.
20. In relation to the risk of suicide, again Dr Miller claims the appellant stated she would rather die in the UK than be killed in Nigeria but the appellant is referring

to her claim that she will be killed either by her husband or the Black Axe gang, yet neither claim has been shown to be credible.

21. If one removes the elements that the appellant claimed was responsible for her mental health needs and presentation and which she claims will lead to a serious, rapid, and irreversible decline in her state of health or significant reduction in her life expectancy, other than the general fear of returning to Nigeria and the reality of the same for herself and her children, there is nothing to support the appellant's claim that the test set out in question 4 of Dr Miller's letter of 9 September 2021 is met. I make a finding of fact accordingly.
22. It is not disputed the appellant will be returned to Nigeria as a single mother with three young children. It is a preserved finding that she will have support from her brother who lives in Nigeria. The appellant lived in Nigeria until the age of 27. The appellant is also a very intelligent woman educated to degree level and it was not made out she would not be able to find employment and be able to support herself and the children, with the help of family members if required.
23. A letter from Solace was provided to the First-tier Tribunal as was evidence regarding the availability of medical treatment in Nigeria, which was considered by Judge Brooks. It was found at [68] that treatment by psychologists is available in Nigeria as is psychiatric counselling, that treatment facilities are mainly located in urban areas, that the appellant will be returned to an urban area and would therefore be able to access medication treatment for her mental health conditions in Nigeria.
24. The consequences of the preserved findings are that the starting point in relation to this appeal has to be a finding that no danger had been proved to the appellant or the children if they are returned Nigeria. That is not to say the appellant has not demonstrated a subjective fear, that is clearly recorded by Dr Miller, but such a claim has not been shown to be objectively well-founded. As the basis of the suggestion the appellant would not have access to medical treatment was as a result of her reaction to facing a situation of danger in Nigeria, and that no such danger existed, Ms Young submitted there was no reason why she would not be able to access the services and treatment that is available to her in Nigeria. I agree.
25. Although Mr Holmes in his submission suggested that what was required was a detailed analysis of what will be available in Nigeria, as the background material painted a mixed picture, it is a preserved finding that adequate services to meet the appellant's needs are available in Nigeria. I find that has also not been shown not to be the cases when re-examining the evidence.
26. It was also submitted on the appellant's behalf by Mr Holmes that it was the second part of the Paposhvili test that required further consideration which meant it was for the Secretary of State to prove the issues. It was argued that as there are inadequate facilities and treatment available in Nigeria the Secretary of State could not discharge the burden as the required treatment was not available and cannot be accessed. It was submitted that as the procedural requirement of Article 3 was not satisfied, on the basis the Secretary of State had not done enough, the test was met, and the appeal should be allowed.
27. The test referred to by Mr Holmes, and not challenged by Ms Young, is whether the appellant faces 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 her state of health resulting in intense suffering or to a significant reduction in life expectancy': see [Paposhvili v. Belgium \(Application No. 41738/10\) \(13 December 2016\)](#).
28. At [23] of AM (Zimbabwe) [2020] UKSC 17 it is written:

23. Its new focus on the existence and accessibility of appropriate treatment in the receiving state led the Grand Chamber in the Paposhvili case to make significant pronouncements about the procedural requirements of article 3 in that regard. It held
- (a) in para 186 that it was for applicants to adduce before the returning state evidence “capable of demonstrating that there are substantial grounds for believing” that, if removed, they would be exposed to a real risk of subjection to treatment contrary to article 3;
 - (b) in para 187 that, where such evidence was adduced in support of an application under article 3, it was for the returning state to “dispel any doubts raised by it”; to subject the alleged risk to close scrutiny; and to address reports of reputable organisations about treatment in the receiving state;
 - (c) in para 189 that the returning state had to “verify on a case-by-case basis” whether the care generally available in the receiving state was in practice sufficient to prevent the applicant’s exposure to treatment contrary to article 3;
 - (d) in para 190 that the returning state also had to consider the accessibility of the treatment to the particular applicant, including by reference to its cost if any, to the existence of a family network and to its geographical location; and
 - (e) in para 191 that if, following examination of the relevant information, serious doubts continued to surround the impact of removal, the returning state had to obtain an individual assurance from the receiving state that appropriate treatment would be available and accessible to the applicant. Page 11 These procedural obligations on returning states, at first sight very onerous, will require study in paras 32 and 33 below.

29. At [32 – 33] it was found:

32. The Grand Chamber’s pronouncements in the Paposhvili case about the procedural requirements of article 3, summarised in para 23 above, can on no view be regarded as mere clarification of what the court had previously said; and we may expect that, when it gives judgment in the Savran case, the Grand Chamber will shed light on the extent of the requirements. Yet observations on them may even now be made with reasonable confidence. The basic principle is that, if you allege a breach of your rights, it is for you to establish it. But “Convention proceedings do not in all cases lend themselves to a rigorous application of [that] principle ...”: *DH v Czech Republic* (2008) 47 EHRR 3, para 179. It is clear that, in application to claims under article 3 to resist return by reference to ill-health, the Grand Chamber has indeed modified that principle. The threshold, set out in para 23(a) above, is for the applicant to adduce evidence “capable of demonstrating that there are substantial grounds for believing” that article 3 would be violated. It may make formidable intellectual demands on decision-makers who conclude that the evidence does not establish “substantial grounds” to have to proceed to consider whether nevertheless it is “capable of demonstrating” them. But, irrespective of the perhaps unnecessary complexity of the test, let no one imagine that it represents an undemanding threshold for an applicant to cross. For the requisite capacity of the evidence adduced by the applicant is to demonstrate “substantial” grounds for believing that it is a “very exceptional” case because of a “real” risk of subjection to “inhuman” treatment. All three parties accept that Sales LJ was correct, in para 16, to describe the threshold as an obligation on an applicant to raise a “prima facie case” of potential infringement of article 3. This means a case which, if not challenged or countered, would establish the infringement: see para 112 of a useful analysis in the Determination of the President of the Upper Tribunal and two of its senior judges in *AXB v Secretary of State for the Home Department* [2019] UKUT 00397 (IAC). Indeed, as the tribunal proceeded to explain in para 123, the arrangements in the UK are such that the decisions whether the applicant has

adduced evidence to the requisite standard and, if so, whether it has been successfully countered fall to be taken initially by the Secretary of State and, in the event of an appeal, again by the First-tier Tribunal.

33. In the event that the applicant presents evidence to the standard addressed above, the returning state can seek to challenge or counter it in the manner helpfully outlined in the judgment in the Paposhvili case at paras 187 to 191 and summarised at para 23(b) to (e) above. The premise behind the guidance, surely reasonable, is that, while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state. What will most surprise the first-time reader of the Grand Chamber's judgment is the reference in para 187 to the suggested obligation on the returning state to dispel "any" doubts raised by the applicant's evidence. But, when the reader reaches para 191 and notes the reference, in precisely the same context, to "serious doubts", he will realise that "any" doubts in para 187 means any serious doubts. For proof, or in this case disproof, beyond all doubt is a concept rightly unknown to the Convention.
30. The result of this is that the current threshold to receive the right to remain in the UK to prevent a breach of your Article 3 rights (in medical cases) is:
- i) the imminence (i.e. likely "rapid" experience) of intense suffering or death in the country to which the Home Office is seeking to return you,
 - ii) which may only occur because of the non-availability in that country of treatment
 - iii) and that treatment is available to you in the UK.
31. In the later case of AM (Art 3: health cases) Zimbabwe [2022] UKUT 00131 the Upper Tribunal held that the first question was whether P had discharged the burden of establishing that he or she was a "seriously ill person". If so had 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"? In relation to (ii) (a) "intense suffering" was required, not simply that the condition would worsen upon removal. Many cases were likely to turn on the availability of and access to treatment in the receiving state which was more likely to be found in reports by reputable organisations or clinicians based in the receiving state or country experts rather than medical experts based in the UK. It was only after the threshold test had been met and Article 3 was applicable that the returning states obligations summarised at [130] of Savran became relevant.
32. The UT in AXB (Art 3 health:obligations:suicide) Jamaica [2019] UKUT 397 considered the case of Savran and held that (i) In a case where an individual, asserts that his removal from the Returning State would violate his Article 3 ECHR rights because of the consequences to his health, the obligation on the authorities of a Returning State dealing with a health case is primarily one of examining the fears of an applicant as to what will occur following return and assessing the evidence. In order to fulfil its obligations, a Returning State must provide "appropriate procedures" to allow that examination and assessment to be carried out. In the UK, that is met in the first place by an examination of the case by the Secretary of State and then by an examination on appeal by the Tribunal and an assessment of the evidence before it; (ii) There is no free-standing

procedural obligation on a Returning State to make enquiries of the Receiving State concerning treatment in that State or obtain assurances in that regard. Properly understood, what is referred to at [185] to [187] of the Grand Chamber's judgment in Paposhvili concerns the discharge of respective burdens of proof; (iii) The burden is on the individual appellant to establish that, if he is removed, there is a real risk of a breach of Article 3 ECHR to the standard and threshold which apply. If the appellant provides evidence which is capable of proving his case to the standard which applies, the Secretary of State will be precluded from removing the appellant unless she is able to provide evidence countering the appellant's evidence or dispelling doubts arising from that evidence. Depending on the particular circumstances of the case, such evidence might include general evidence, specific evidence from the Receiving State following enquiries made or assurances from the Receiving State concerning the treatment of the appellant following return. The tribunal concluded that the threshold in suicide cases was the N threshold rather than any other specifically for mental health (the N threshold being the one then generally applicable in Article 3 case).

33. The medical evidence indicates that SB has found it difficult to keep her emotions in control and, indeed, she was moved to tears on more than one occasion during the course of the hearing although was able to remain in the hearing room to hear submissions being made.
34. Dr Miller in her letter reports having to step in to treat SB if there is a reoccurrence of her PTSD symptoms for which she required a prescription of diazepam to calm her down. There is also a reports of her whole family being distressed because of her uncontrollable crying. The letter further states SB had been doing well and that the bottom line is that her uncertain asylum status means that she feels unsafe and she is periodically tipped into distress.
35. There is insufficient objective verification for the claim/belief that SB will be unsafe if returned to Nigeria for any reason she sought to rely on in relation to her protection claim. That was dismissed by First-tier Tribunal as lacking credibility.
36. It is understandable that SB may feel her status and ability to remain in the UK is not secure and therefore unsafe which is objectively verifiable, as it accurately reflects the reality of the situation in which she finds herself.
37. Dr Miller was asked in the 9 September 2021 letter whether removal to Nigeria would mean SB faced a real risk of being exposed to a serious, rapid, irreversible decline in the state of her health resulting in intense suffering or significant reduction in life expectancy as a result of her mental health issues. That question reflects the test set out in AM (Zimbabwe) as per the decision in Paposhvili.
38. I agree with the assessment of Dr Miller that the answer to that question is context dependent. If SB had had a credible fear of the State, who she perceived as those being responsible for causing her harm yet also for providing her with medical support and treatment, and that as a result of such a credible fear she was not able to approach the medical authorities as she believed something bad will happen to her, that will be one model. The consequences of such may mean she was so frightened that she would not have access to treatment that was available resulting in a serious decline in her mental health. Based on factual findings made in this appeal that is not the scenario. The appellant claimed a fear of nonstate actors and others, yet that claim has been rejected as lacking credibility. The First-tier Tribunal specifically noted that the appellant had lived for a while in Lagos with no evidence of anything adverse happening to her. I find it was not made out she could not do so again.
39. It is clear from the answers provided by Dr Miller that as soon as SB perceives a threat she deteriorates into a state of acute distress with the triggering of PTSD symptoms and nightmares intrusive memories. The causation of her PTSD, as the issues the appellant claimed forced her to flee Nigeria have been found to lack

credit and not found to have occurred, raises questions of its own if this appeal is being pursued before me on the basis that the diagnosis of Dr Miller is accurate.

40. It is clear that SB will receive suitable treatment within the UK to assist her if her appeal is dismissed. It is a preserve finding that suitable treatment to meet her health needs is available in Nigeria. It is also a preserved findings that the appellant has a relative, namely a brother, who will be able to provide her with emotional support within Nigeria, a country with which she is very familiar, with having lived there in the past.
41. In relation to the question of whether SB's mental health would deteriorate to the point of suicide Dr Miller notes that although in the past SB has talked about it being better to die than to be killed in Nigeria, since she has become a parent she had not expressed suicidal ideation and has never expressed thought of harming the children in a crisis, which Dr Miller records may require a further risk assessment if there are negative developments in the situation which SB may perceive to be the case if the appeal is dismissed but I can only assess the merits of the case on the basis of the evidence currently available
42. I find that if the second part of the Paposhvili test arose, it would require consideration of whether the Secretary of State has shown that there is suitable treatment available for SB in Nigeria. I am satisfied the Secretary of State has established that such treatment will be accessible to SB and that even if not to the same standard as that available in the UK it has not been shown that it will not be sufficient to assist SB with meeting her mental health needs.
43. In Paposhvilli at [190] it was found:

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).

44. It was found at [114] that means no more than requiring the assessing authorities to consider what treatment will be available and whether the individual appellant will be able to access it. It does not diminish the high threshold which applies to establishing that there are substantial grounds for believing that there is a real risk of a breach of Article 3 arising from the conditions in the receiving state. The burden of establishing that remains with the appellant.
45. In article 3 health cases even after Paposhvili the appellant is required to show that there is a real risk that she would be 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. I do not find that SB has established this aspect of her case to the required standard.
46. I do not find it made out that the procedural requirements of Article 3 ECHR based upon the guidance set out in *AM (Zimbabwe)* establish that SB is entitled to remain in the United Kingdom on the facts. It is not made out that if she is returned to Nigeria she will face a real credible risk of a deterioration in her mental health sufficient to cross the Article 3 threshold for the above reasons.

Decision

47. The appeal is dismissed.

C J Hanson

Judge of the Upper Tribunal
Immigration and Asylum Chamber

14 August 2023