



IN THE UPPER TRIBUNAL
IMMIGRATION AND ASYLUM CHAMBER

Case Nos: UI-2023-004409
First tier number: PA/51646/2023

THE IMMIGRATION ACTS

Decision & Reasons Issued:

On 24th of September 2024

Before

UPPER TRIBUNAL JUDGE BRUCE

Between

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Appellant

and

MS (Angola) + 2
(anonymity order made)

Respondent

Representation:

For the Appellant: Mr M. Diwnycz, Senior Home Office Presenting Officer
For the Respondent: Mr S. Wintor, Counsel instructed by Rutherford Sheridan Solicitors

Heard in Edinburgh on the 4th September 2024

DECISION AND REASONS

1. The Respondent is a national of Angola born in 1977. Her dependents are her daughters, D1 born in February 2004 and D2 born in February 2009. On the 1st September 2023 the First-tier Tribunal (Judge Kempton) allowed their appeal on human rights grounds. The basis of Judge Kempton's decision was that it would be a violation of the United Kingdom's obligations under Article 3 ECHR to return this family to Angola because D1 suffers from the most severe form of sickle cell anaemia. Judge Kempton was satisfied that there was a real risk that on return to Angola D1 would suffer a serious and irreversible decline in her health resulting in her early death and/or intense suffering amounting to torture, inhuman or degrading treatment. The appeals of her mother and sister were allowed in line with hers.

2. The Secretary of State now has permission to appeal against that decision on two grounds.
3. The first is that the decision of the First-tier Tribunal is incomplete. This was a case that came before the Tribunal because the Respondent and her dependent daughters had claimed asylum, asserting that they faced a real risk of harm from the police in Luanda. The Tribunal had dismissed that aspect of their claim on the basis that they had, on the Respondent's own evidence, already successfully managed to internally relocate within Angola to avoid the abuse of the police in the capital. Having made that finding, the Tribunal did not consider the asylum grounds any further. It then proceeded to assess the Article 3 medical claim on the basis that her assertions about Luanda, and why she could not return there, were true. The Secretary of State submits that what the Tribunal should have done was to make a finding on whether the Respondent did in fact have anything to fear in Luanda. Only then could it properly consider whether there was a real risk that D1 would be unable to access treatment anywhere in Angola.
4. For the Respondent Mr Winton accepts that this ground is made out. He submits, however, that whether the omission to make credibility findings was material turns on whether the second of the Secretary of State's grounds succeeds, a submission with which Mr Diwnycz agrees.
5. The second ground is concerned with the Tribunal's analysis of the questions set out in AM (Art 3; health cases) Zimbabwe [2022] UKUT 00131 (IAC). In brief summary it is the Secretary of State's case that the Tribunal was not rationally entitled to place the weight that it did on the evidence of Consultant Haematologist Dr Louisa Mcilwain of Glasgow Royal Infirmary about the availability of suitable medication in Angola:

"...Whilst accepted, that the Doctor is able to provide sound evidence as to the appellants daughters medical position, they step outside their remit, in providing an opinion on the country situation in Angola. It is clear that when compared against the more up to date Country Information request which was before the tribunal [39], the Doctor's opinion that hydroxycarbamide is unavailable throughout Angola, is at odds with the objective evidence, which must call into question whether his other opinions, following his own research are in fact accurate. Furthermore, his opinion that the appellant was unable to access the required medications in Angola, is based on an historic position, prior to her flight from that country, and not the more up to date position as indicated in the CPIN quoted. It is respectfully asserted, that given the FTTJ's finding on article 3 appears to be based on the Doctors evidence alone, which in turn relies upon an un-sourced and out of date (2015) report, any conclusion must be misdirected in law".

Discussion and Findings

6. The First-tier Tribunal's decision is in one fundamental way difficult to understand. The asylum claim – that the Respondent had come to the adverse attention of the police in Luanda because of her political activities – is dismissed on the basis of her own evidence that she spent three years availing herself of an internal flight alternative in Benguela, a city over 600km from the capital. The

Tribunal does not appear, at this juncture, to consider whether it was unduly harsh to expect the Respondent to return to Benguela. Nor, as the grounds of appeal contend, does it engage in any further analysis of the asylum claim.

7. The Tribunal then moves on to considering Article 3. In doing so it accepts that when the Respondent and her children were living in Benguela they were living hand to mouth, with the result that the Respondent was unable to obtain medical treatment for a third daughter – D1’s twin sister – who suffered from the same form of sickle cell as D1. This girl died in Benguela. Although this is not an argument made on behalf of the Respondent in her Rule 24 response, it seems to me a *Robinson* obvious point that if she faced such hardship that one of her children died in Benguela it was probably ‘unduly harsh’ to expect her to return there with D1, who has the same medical condition as her deceased sister.
8. That this is so is impliedly accepted in the Secretary of State’s grounds, which are centred on the situation in Luanda: any errors in the internal flight analysis are immaterial if the family are able to return to the capital, and it is the Secretary of State’s case that D1 would be able to access adequate medical care there. It is therefore to that matter that I now turn.
9. In AM (Article 3 - health cases) [2022] UKUT 00131 (IAC) the Upper Tribunal distilled the applicable jurisprudence to the following guidance, set out in the headnote:

1. In Article 3 health cases two questions in relation to the initial threshold test emerge from the recent authorities of AM (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17 and Savran v Denmark (application no. 57467/15):

(1) Has the person (P) discharged the burden of establishing that he or she is “a seriously ill person”?

(2) Has P adduced evidence “capable of demonstrating” that “substantial grounds have been shown for believing” that as “a seriously ill person”, he or she “would face a real risk”:

[i] “on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment,

[ii] of being exposed

[a] to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering, or

[b] to a significant reduction in life expectancy”?

2. The first question is relatively straightforward issue and will generally require clear and cogent medical evidence from treating physicians in the UK.

3. The second question is multi-layered. In relation to (2)[ii][a] above, it is insufficient for P to merely establish that his or her condition will worsen upon removal or that there would be serious and detrimental effects. What is required is “intense suffering”.

The nature and extent of the evidence that is necessary will depend on the particular facts of the case. Generally speaking, whilst medical experts based in the UK may be able to assist in this assessment, many cases are likely to turn on the availability of and access to treatment in the receiving state. Such evidence is more likely to be found in reports by reputable organisations and/or clinicians and/or country experts with contemporary knowledge of or expertise in medical treatment and related country conditions in the receiving state. Clinicians directly involved in providing relevant treatment and services in the country of return and with knowledge of treatment options in the public and private sectors, are likely to be particularly helpful.

4. It is only after the threshold test has been met and thus Article 3 is applicable, that the returning state's obligations summarised at [130] of Savran become of relevance - see [135] of Savran.

10. In respect of the initial threshold test, the Respondent family had, it is not contested, demonstrated that D1 is a "seriously ill person".
11. The next question was whether the Respondent family had adduced evidence capable of demonstrating that substantial grounds have been shown for believing that D1 faced a real risk of being exposed to Article 3 harm on account of the absence of appropriate treatment in the receiving country *or* the lack of access to such treatment. As the Tribunal note in AM, this enquiry is still part of the initial threshold test, and the burden lies on the claimant.
12. Here the Respondent family had relied on the expert opinion of Dr Louisa Mcilwain, one of the physicians treating D1 at Glasgow Royal Infirmary. In her letter of the 3rd September 2021 Dr Mcilwain said this:

"[D1] is a patient of mine with sickle cell disease in the form of haemoglobin SS. This is a severe, inherited condition, which therefore affects patients lifelong. Her red cells have a predisposition to form in a sickle shape, which results in reduced oxygen delivery to tissues, severe pain and sometimes life threatening episodes. The risk and severity of these episodes is exacerbated by infections (including malaria), operations, dehydration, stress and episodes of generally being unwell, although they can also occur with no apparent precipitant. There episodes are generally termed sickling crises, and, since coming to the country a year ago, [D1] has had 5 admissions, lasting a few days to a week.

Since she left Angola, she has been started on Hydroxycarbamide, which is one of the mainstays of medication for this condition. Her general health has improved markedly since starting this. One of her admissions revealed some abnormalities on brain imaging due to previous sickling episodes, We await follow up investigations of this as if progressive we would need to consider a regular transfusion programme (every 4-6 weeks) to reduce the risk of stroke.

Sickle cell disease requires regular expert monitoring to reduce the chance of acute episodes and manage long term complications, which are unfortunately significant due to the fact that this disease affects all organs. In this country, patients with sickle cell disease have an average life expectancy in their 40s. I am not an expert on the health care provision in Angola, but am aware that it is markedly reduced compared to what is on offer in the UK. I do not think [D1] had access to Hydroxycarbamide prior to leaving Angola, and she certainly did not have access to the outpatient follow up or the hospital that she has received during her admissions here. I do not know the life expectancy of patients with sickle cell disease in Angola but in Africa in general (which is a generalisation) the average is 20 years.

Hydroxycarbamide is recognised as significantly improving the life expectancy of patients with sickle cell disease, so it not only improves quality of life, but duration. Patients with sickle cell disease are at risk of kidney, heart and lung complications, as well as strokes and death in pregnancy, and it is for all of these reasons that these patients are monitored closely in outpatient clinic, and in the UK their care is multidisciplinary, involving multiple clinicians and specialties over a lifetime. Access to ITU is critical for many patients in view of the fact that sickling crises can be life threatening. For these reasons I strongly suspect that her medical care, and therefore chance of leading a healthy life for as long as possible is much greater within the UK than Angola”.

13. On the 25th October 2022 Dr Mcilwain provided a second letter. By way of update about D1's condition she says this:

“Since the letter in September, she has had 8 inpatient stays, including a short period in intensive care. During admissions, she has required intravenous access (often with long indwelling vascular access lines), intravenous fluids and analgesia. She has had regular imaging in view of her sickle cell disease, and required CT brains and multiple chest xrays. We are aiming to control her condition with Hydroxycarbamide therapy, but, at present, it is not preventing the numerous hospital admissions, and we may require additional therapy.

This is likely to involve outpatient intravenous therapy in the first instance, but bone marrow transplantation remains a possibility, though certainly not imminently likely. There are major side effects associated with bone marrow transplantation, so it is not something that we would do unless there were no alternatives.

My understanding is that [D1] would have no access to any of these interventions in Angola. Her life would certainly be full of severe painful episodes, for which she is likely to get inadequate pain relief. I do not believe she would have access to any of the disease modifying medication in Angola. Estimating life expectancy in Angola is difficult, but I have reviewed the

literature, in a paper published in 2015, it suggests that the average life expectancy is <18 years of age for a patient with sickle cell disease in Angola. In the UK, the average life expectancy is in the 40s, and, increasingly, there is expectation that patients will live to their 50s and 60s with the newer treatment and access to good health care.

14. A third letter, dated the 7th August 2023, is couched in similar terms. By the time that Dr Mcilwain had written this letter, D1 had spent 41 days in the preceding year in hospital, receiving a variety of treatments including blood transfusion, vitamins, analgesics including morphine, and the anti-sickling agent hydroxycarbamide. Dr Mcilwain had, it would seem, gained access to more information about Angola. She writes that the age expectancy of patients with D1's condition in that country is 5 years old. She deduces from this that D1 would likely face a significant reduction in life expectancy should she return there. Dr Mcilwain further observes that the risk of infection with HIV through blood transfusion is "not insignificant".
15. Pausing here, I note that no issue was taken with Dr Mcilwain's status as a Consultant Haematologist. She was not an expert brought in specifically to provide 'snapshot' evidence: she has been involved in D1's care over an extended period. She was clearly well placed to offer an opinion on D1's medical condition and prognosis. No point was taken as to her ability, as a medical professional who understands her obligations to the court, to report objectively on her findings. As a Consultant Haematologist it can be expected that Dr Mcilwain was able to read, digest and understand academic papers and reporting on matters such as the treatment of sickle cell in jurisdictions other than our own. It was therefore evidence to which the First-tier Tribunal was entitled to give significant weight.
16. What was the evidence adduced by the Secretary of State? Although the grounds of appeal refer to a CPIN, Mr Diwnycz explains that this is an error. There has not been a CPIN on Angola since 2019. What the Secretary of State had submitted in this appeal was a 'Response to an information request' dated 30th April 2020 which contained the following information:

Sickle cell disease treatment

1.1.1 Information obtained from MedCOI sources indicated the availability of the following from public facilities in Luanda:-

- In and outpatient treatment and follow up by haematologists and general practitioners.
- Clinical treatment in case of sickle cell crises and transfusion of red blood cells.
- Hydroxycarbamide (hydroxyurea), amoxicillin, clavulanic acid, colecalciferol and paracetamol

1.1.2 A June 2017 Angop article noted that 'A centre for assistance to patients with sickle cell anemia was unveiled on Monday at Cajueiros General Hospital in Cazenga municipality, Luanda.'

1.1.3 The Foreign and Commonwealth Office (FCO) Travel Advice, Health section noted that 'Outside Luanda health care is very limited.'

1.1.4 The Allianz Care profile of healthcare in Angola noted that 'While it is free, public healthcare in Angola is severely underfunded and understaffed. It's also extremely difficult to access...'

1.1.5 The Foreign and Commonwealth Office (FCO) provided a list of medical facilities/practitioners in Luanda which were apparently largely private.

17. It should be noted that the footnote to paragraph 1.1.1 clarifies that the information available confirmed that it was possible to obtain such medications in Luanda, but not how accessible that might be.
18. This was the evidence before the Tribunal. Returning to the grounds, I take each point made in turn.
19. The first is that Dr Mcilwain stepped 'outside her remit' in saying what she did about Angola. There certainly are cases before this Tribunal in which doctors speculate or generalise about the position in some other country; there are also cases where doctors simply accept at face value what the patient is telling them about that matter. This however is not one of them. As Dr Mcilwain makes clear, she has conducted research into sickle cell care in Angola. She refers to the academic papers that she has read. In the absence of any challenge to her own expertise to understand such papers, that was obviously a matter within her remit as a Consultant Haematologist. Her conclusion that hydroxycarbamide was not available to D1 is drawn not just from what the patient has told her, but from her own clinical observations of how her patient responded once this medication was administered: her condition "markedly" improved. In respect of D1's self-reporting it is also relevant to note that at no point was the evidence about the treatment she had received in Angola challenged; nor, as Mr Diwnycz agrees, was the evidence that her sister had died through lack of treatment ever placed in issue.
20. The second submission made is that when Dr Mcilwain's opinion was compared to the "more up to date Country Information request which was before the tribunal" it was found to be inaccurate, specifically in regard to the availability of hydroxycarbamide. Before me Mr Diwnycz properly conceded that this is not as a matter of fact correct, because the short Medcoi report that was before the Tribunal in fact dated from April 2020, and Dr Mcilwain makes the assertions that she does in August 2023, just a matter of weeks before the First-tier Tribunal hearing.
21. Ultimately the question is whether there was evidence before the Tribunal capable of discharging the burden of proof in respect of Article 3. It was accepted that D1 is a seriously ill person, and that if she does not have access to treatment she will suffer a serious, rapid and irreversible decline, followed by death. The only matter in issue was that access. I am satisfied that on the evidence the Tribunal was entitled to conclude as it did. The unchallenged evidence was that this single mother led household had been living hand to mouth in Angola, with the Respondent struggling to obtain and pay for the most basic care for her

daughters. It was not in issue that one of them had died as a result of an inability to access adequate medical care. The most up to date evidence before the Tribunal indicated that life expectancy for people with D1's condition in Angola was 5 years. All of that had to be measured against the fact that this young woman is sadly extremely ill, and requires complex treatment not only to prolong her life as much as possible, but to shield her from the severe pain that comes with a sickling crisis. I am satisfied that the Tribunal was entitled to reach the decision that it did.

Decisions

22. The decision of the First-tier Tribunal is upheld and the Secretary of State's appeal is dismissed.
23. There is an order for anonymity.

Upper Tribunal Judge Bruce
Immigration and Asylum Chamber

3rd September 2024