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What does the *AM (Zimbabwe)* case mean for people living with HIV at risk of removal?

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On 29 April 2020, the UK Supreme Court (UKSC) gave judgment in *AM (Zimbabwe) v Secretary of State for the Home Department* [2020] UKSC 17. *AM* is a vital case about the construction of 'medical grounds' in immigration appeals including Article 3 of the European Convention on Human Rights (ECHR). This briefing seeks to inform you about the case of *AM*, how it departed from previous UK caselaw, and how the HIV sector can utilise an understanding of *AM* to protect the human rights of people living with HIV facing removal.

1. What was the AM (Zimbabwe) case? [have side banner with definition of Article 3]

AM arrived in the UK in 2000 from Zimbabwe and was granted Indefinite Leave to Remain (ILR) in 2004. In 2003 he was diagnosed with HIV. In 2011, he started taking ART but experienced intolerable side effects. He was provided with a different ART which increased his CD4 count, and his viral load became undetectable.

In 2009, AM was sentenced to nine years imprisonment for several criminal offences. Upon his release from prison in 2013 the Secretary of State sought to deport him.[1] AM needed to continue his HIV treatment, and in Zimbabwe, whilst a range of anti-retroviral medications were available, the one he was responding well to was not. Without access to this medication, his CD4 blood count would fall again, leaving him prey to infections which, if left untreated, would lead to his death.

Article 3 of the European Convention on Human Rights prohibits torture, and "inhuman or degrading treatment or punishment"

[1] The terms 'deportation' and 'removal' are often used interchangeably but deportation has a specific legal meaning. Deportation is the enforced removal of someone in the public interest. This is usually someone who has been convicted of a crime resulting in more than 12 months' imprisonment. However, this briefing paper applies to anyone facing removal or deportation.

The UKSC ruled that removing AM to Zimbabwe, where he would not be able to access the medication he needed, would be a breach of Article 3 of the ECHR. The judgment in *AM* was significant because it lowered the previously very high, stringent threshold in medical cases of near death.

The judgment mirrored the Grand Chamber of the ECtHR judgment in *Paposhvili v Belgium* Application no. 41738/10, ECHR, 13 December 2016, which found that the test in Article 3 medical cases is not restricted to a person at imminent risk of dying, but is about cases where there is 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 their state of health resulting in intense suffering or to a significant reduction in life expectancy"**[2]

It is important to note that the UKSC decided not to address the argument presented by AM that the medical reports in his individual case sufficed to cross the Article 3 threshold, mainly because they formed part of AM's initial Article 8 claim (which was dismissed) and because they were more than five years old by the time the case went to the UKSC. AM's case was therefore remitted to the Upper Tribunal, to consider up-to-date evidence, properly directed by the *Paposhvili* substantive and procedural requirements. This is yet to be heard.

2. How did AM (Zimbabwe) differ from preceding case law regarding HIV and removal?

D v United Kingdom (1997)

The applicant, known only as 'D', was born in St Kitts. He arrived in the UK in 1993 and was diagnosed with HIV whilst in prison in 1994. He was released on license in 1996 and placed in immigration detention pending his removal to St Kitts. His prognosis was very poor and limited to 8-12 months. If he were to be removed to St Kitts, his prognosis would be reduced to less than half that time. He was receiving end of life care in the UK, as HIV treatment was only just becoming available, so the case was presented in the ECtHR as 'D is going to die, and the question is where?' The ECtHR determined that his abrupt withdrawal from the facilities and separation from his carers would hasten his death and there was a serious danger that conditions of adversity in St Kitts would subject him to acute mental and physical suffering. **"In view of these exceptional circumstances and bearing in mind the critical stage now reached in the applicant's fatal illness, the implementation of the decision to remove him to St Kitts would amount to inhuman treatment by the respondent State in violation of Article 3"**[3]

N v United Kingdom (2008)

'N' arrived in the UK from Uganda in 1998 and claimed asylum. The day after her arrival, she was admitted to hospital and diagnosed with HIV, tuberculosis, and five months later she was diagnosed with Kaposi's sarcoma. Her CD4 count was 10, but her condition stabilised with ART. Her asylum claim based on what she had suffered in Uganda was rejected, however she was allowed to appeal under Article 3. By the time her case was heard in the House of Lords in 2005 (the precursor to the Supreme Court) her CD4 count was 414 and she was no longer at risk of imminent death. The judgment stated that **"The Court accepts that the quality of the applicant's life, and her life expectancy, would be affected if she were returned to Uganda. The applicant is not, however, at the present time critically ill."**

The Court determined that the case **"does not disclose very exceptional circumstances, such as in *D. v the United Kingdom* (cited above), and the implementation of the decision to remove the applicant to Uganda would not give rise to a violation of Article 3 of the Convention."**[4]

The ECtHR had backtracked significantly from D. There were a handful of cases from Sweden, Denmark,

[2] AM (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17 (29 April 2020) [§183].

[3] D v United Kingdom [1997] ECHR 25 [53]

[4] N v United Kingdom [2008] ECHR 453 [50]-[51]

Switzerland, Netherlands where the ECtHR ruled that the person wasn't ill enough. Some were indistinguishable from *N* where they had presented very ill, with AIDS defining illnesses, but were not ill at the time when removal was being considered. That they would become very unwell very quickly without medication was not considered to be a breach of Article 3. The UK immigration tribunals applied the *N* decision in a far-reaching way, denying almost any requests by non-nationals not 'legally' allowed to remain in the UK. For example, in a decision by the Upper Tribunal in 2011, it was held that the deportation of a non-national receiving kidney dialysis treatment in the UK would not violate Article 3, even though the applicant would not receive the treatment in India.[5] The tribunal ruled that removal would only be unlawful if the individual in question was effectively dying.

3. How does the medical threshold in AM apply in practice?

There are three main aspects to the medical threshold:

Aspect 1: Is there an absence of appropriate treatment?

Is the HIV treatment required available in the returning state? For instance, in *AM* the treatment required for his HIV was not available in Zimbabwe. There are a number of Country Guidance cases - namely Tribunal judgments - outlining the situation in different countries/regions, some of which may be highly relevant where healthcare provision is considered. However, it is of note that (1) there are not Country Guidance cases for every country and (2) some Country Guidance cases can be significantly out of date. The courts have made clear that Country Guidance cases are therefore not *"set in stone"* and can be departed from.[6]

The Home Office also publishes Country Policy and Information Notes (CPINs) on different country contexts, and most will include a chapter on healthcare, including treatment for HIV, or even a separate CPIN on healthcare. Again, given the impact of the COVID-19 pandemic of healthcare infrastructure around the world, this should be borne in mind when considering the situations as explained in Tribunal judgments or Home Office policy. Up-to-date evidence should usually be sought in line with the guidance below.

Aspect 2: Is any treatment accessible?

AM requires consideration of the barriers that exist in accessing treatment, either individually or systemically. For instance, if returned would this individual be able to afford private treatment if that is the only means to obtain the medical treatment they need? Similarly, are there structural factors that render treatment inaccessible for particular groups? For example, LGBTQ+ migrants may face specific health inequalities or discrimination.

Aspect 3: If the treatment is unavailable or the individual is unable to access treatment, what would be the impact on their health?

It must be demonstrated that the ultimate impact would meet the test in *AM* in light of the unavailability and/or inaccessibility of treatment. Namely, that removal would subsequently lead to a **serious, rapid, and irreversible decline in their state of health resulting in intense suffering or to a significant reduction in life expectancy.**

[5] GS (Article 3 – health – exceptionality) India [2011] UKUT 35 (IAC)

[6] The Upper Tribunal in *DSG & Others (Afghan Sikhs: departure from CG)* [2013] UKUT 148, held that country guidance cases are not "set in stone" and a judge may depart from existing country guidance in circumstances prescribed by the relevant Practice Direction and Guidance Note [§26]. As summarised at §20 of the judgment, the 2011 Guidance Note outlines at §11 and §12 that where country guidance has become outdated by reason of developments in the country in question, on the basis of credible fresh evidence relevant to the issue, the judge will reach the appropriate conclusion on the evidence, taking into account the conclusion in the CG case so far as it remains relevant.

4. What guidance did the UKSC give on meeting this threshold?

The UKSC gave guidance regarding the evidence an Appellant must adduce to establish a violation of Article 3. The evidence must be capable of demonstrating "substantial" grounds for a "very exceptional case" because of a real risk of subjection to inhuman treatment. The Court stated, in no unclear terms, that the threshold places an obligation on the applicant to raise a "prima facie case" of potential infringement of Article 3, meaning that if it were not challenged or countered, it would establish the infringement.[7] Therefore, despite *AM* representing an advancement and improvement in the law following on from *N*, **the threshold remains extremely high and arguably does not afford wide enough protection in this context.**

However, it is important to remember that the UKSC also endorses the approach of *Paposhvili* in relation to procedural requirements:

- it was for the returning state to "dispel any doubts raised" (meaning serious doubts) by the evidence adduced in support of any application under Article 3; [§187]
- 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 [§189]
- that the returning state also had to consider the accessibility of the treatment to the particular applicant, including by reference to its cost, to the existence of a family network and to its geographical location [§190]
- if, following an examination of the relevant information, serious doubts continued to surround the impact of removal, the returning state had to obtain ***individual assurance*** from the receiving state that appropriate treatment would be available and accessible to the applicant [§191].

This clarifies that while it is for the applicant to adduce evidence of their medical condition, current treatment, the suitability of any other treatment, the effect on them of inability to access it etc. the returning state is *better able* to collect evidence about the availability and accessibility of suitable treatment in the receiving state. Once a case is advanced, the burden shifts to the Home Office to dispel any serious doubts. The absence of Home Office evidence in this regard should be highlighted to strengthen our clients' positions.

What type of evidence should we be collecting?

Going back to the three key aspects of the medical threshold and considering how best to evidence each one:

Aspect 1: Is there an absence of appropriate treatment?

Home Office CPINs can be used to our clients' advantage, but often provide generic commentary on healthcare provision, for instance stating HIV treatment is available but not specifying cost, accessibility, regional disparities etc. It is therefore vital to consider instructing a country expert to comment on the availability of treatment across the country.

In addition, medical evidence which addresses the details of a person's individual treatment needs is very valuable. For example, considering the ineffectiveness of certain anti-retroviral methods for some as in *AM*, is vital. Getting comprehensive medical evidence of treatment options or current procedures the person is undergoing in the UK and why this cannot continue to the same or an appropriate standard in the country of removal, will be particularly compelling.

[7] AM (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17 (29 April 2020) [§32].

Aspect 2: Is any treatment accessible?

Think about treatment accessibility individually and systemically. Country expert evidence can address this on an individual level, taking into account the country situation and the person's particular characteristics and needs, as well as expert medical evidence. For example, if the person has severe mental health issues and treatment is difficult to obtain without wider social or familial support, a psychiatric report outlining this would be extremely helpful. Further, systemically, country expert evidence can look at the broader situation for groups of people – including discrimination for people living with HIV, and multiple discrimination on the basis of race, sexuality and/or gender/gender identity.

Aspect 3: If the treatment is unavailable or the individual is unable to access treatment, what would be the impact on their health?

Expert medical evidence from specialists in the UK is needed to demonstrate how the lack of treatment in country of removal would lead to such a significant decline in health such that it would meet the *AM* threshold. It's important to think holistically about medical needs. For example, does the stability and necessity of HIV treatment impact upon other health issues, for instance mental health concerns. If so, do these issues compound in such a way so as to meet the *AM* threshold? Has the person been without treatment before, or on the wrong treatment, in the UK? If so, what was the impact on the person? This can be detailed in witness statements and expert medical evidence.

If the effects were severe, it can provide a useful indicator of what would happen to them if removed and no longer able to access that treatment.

Expert country and medical evidence are often vital to winning cases for people living with HIV. The Article 3 threshold remains high, and the onus is on the Appellant to prove the breach. It's important to be meticulous in collecting medical records as well as the person's own account of previous treatment, if any. It's also important to take clear instructions from the individual about their own circumstances, other health needs, vulnerabilities, or ways in which they could be marginalised or isolated on removal.

Conclusion

AM (Zimbabwe) is an extremely helpful and instructive case when it comes to the rights of migrants living with HIV. But ultimately, the evidential burden on Appellants to demonstrate the impact of removal on their health is a high one. HIV support services can assist the process of collecting evidence and taking details from service users which will help ensure their cases are put forward in the most comprehensive and robust light. Through collaboration between service providers, lawyers, and our clients, we can clearly present an individual's circumstances and the reasons why remaining in the UK is their only means to accessing life-saving treatment.