Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: AA/00844/2014

THE IMMIGRATION ACTS

Heard at Newport	**Decision & Reasons Promulgated**
On 9th March 2016	**On 15th April 2016**

Before

UPPER TRIBUNAL JUDGE GRUBB

Between

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Appellant

and

NA
(ANONYMITY DIRECTION MADE)

Respondent

Representation:
For the Appellant: Mr I Richards, Home Office Presenting Officer
For the Respondent: Mr S Ahmed instructed by 12 Bridge Solicitors

DETERMINATION AND REASONS

1. Pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/2698 as amended) I make an anonymity order. Unless the Upper Tribunal or Court directs otherwise, no report of these proceedings shall directly or indirectly identify the respondent (NA) and her children. This direction applies to both the appellant and to the respondent and a failure to comply with this direction could lead to Contempt of Court proceedings.

Introduction

2. This is the Upper Tribunal's decision following a resumed hearing of this appeal consequent upon the decision of the UT on 16 July 2015 (UTJs Renton and Smith) to set aside the decision of the First-tier Tribunal and to direct that the UT remake the decision.

3. Although this is, in form, an appeal by the Secretary of State to the UT against a decision of the FtT allowing the appeal, for convenience I will refer to the parties as they appeared before the FtT.

Background

4. The appellant is a citizen of Pakistan who was born on [ ] 1974. She arrived in the United Kingdom on 14 May 2011 with her (then) two children. (The appellant has subsequently had two further children (C1 and C2) with a partner in the UK.) The appellant entered with leave as a visitor valid until 11 April 2013. On 6 December 2011 she claimed asylum. The basis of her claim was that she feared her husband as a result of committing adultery in the UK. Her asylum claim was refused on 9 January 2012 and a decision made not to grant her further leave and to curtail her existing leave as a visitor. An appeal against that decision was dismissed by the FtT (Judge Kanagaratnam) on 7 March 2012 and subsequently the appellant was refused permission to appeal to the UT.

5. On 9 April 2013, the appellant made a human rights claim relying upon Article 8 of the ECHR and s.55 of the Borders, Citizen and Immigration Act 2009 (the "BCI Act 2009"). That application was refused on 20 January 2014 and a decision was made to remove the appellant to Pakistan by way of directions as an over-stayer under s.10 of the Immigration and Asylum Act 1999.

6. The appellant appealed to the First-tier Tribunal on asylum, humanitarian protection and human rights grounds. On 17 March 2014 Judge Prior dismissed the appellant's appeal on all grounds. The appellant sought permission to appeal that decision but only to the extent that Judge Prior dismissed her appeal under Article 8. An essential part of that claim then (and now) was the claimed impact upon the health of the appellant's two youngest children born in the UK if returned to Pakistan - C1 born on 10 July 2012 and C2 born on 1 November 2013. Both children have a genetic metabolic disorder known as Congenital Disorder Glycosylation Type 1a ("CDG1a").

7. On 4 August 2014, the Upper Tribunal (Judge Eshun) concluded that Judge Prior's decision to dismiss the appeal under Article 8 involved the making of an error of law. The appeal was, consequently, remitted to the First-tier Tribunal.

8. On remittal, the appeal was heard by Judge B Lloyd. On 22 January 2015, Judge Lloyd allowed the appellant's appeal under Article 8.

9. The Secretary of State sought permission to appeal that decision to the Upper Tribunal on the basis that the Judge had failed, firstly properly to consider the public interest and factors set out in s. 117B of the Nationality, Immigration and Asylum Act 2002 (the "NIA Act 2002") and, secondly properly to apply the approach to the Article 8 where the claim is based upon the impact of removal upon an individual's health.

10. On 4 March 2015, the First-tier Tribunal (Judge V A Osborne) granted the Secretary of State permission to appeal.

11. On 16 July 2015, the Upper Tribunal (UTJs Renton and Smith) decided that the Secretary of State's grounds were made out and so set aside Judge Lloyd's decision to allow the appeal under Article 8 on the basis that he had erred in law in doing so. The appeal was adjourned in order that the decision under Article 8 could be remade at a resumed hearing before the Upper Tribunal.

12. The appeal was eventually listed for a hearing in order to remake the decision before me on 9 March 2016.

The Hearing

13. At the hearing before me, Mr Ahmed represented the appellant and Mr Richards represented the Secretary of State.

14. In relation to the evidence before me, there was a bundle previously before the First-tier Tribunal running to some 349 pages including medical evidence relating to the appellant and C1 and C2 as well as a number of decisions of the higher courts and the Upper Tribunal in relation to the proper approach to Art 8 in health cases.

15. In addition, without objection from Mr Richards, I admitted under rule 15(2A) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/2698 as amended) a supplementary bundle of documents 9 pages long including updated medical evidence.

16. In addition, I heard brief oral evidence from the appellant herself and also from Ms Suzanna Cross, a Specialist Metabolic Paediatric Nurse working at University Hospitals Bristol where C1 and C2 receive treatment.

The Issues and Submissions

17. On behalf of the appellant, Mr Ahmed made a number of oral submissions before me. He relied exclusively upon Article 8 of the ECHR and placed no reliance upon Article 3.

18. Mr Richards, who represented the Secretary of State relied upon the Secretary of State's written submissions dated 13 October 2015 which had been prepared for a previous hearing of the Upper Tribunal.

19. Mr Ahmed focussed his submissions upon the health of C1 and C2. He relied upon the oral evidence of the appellant and her written statement of 15 January 2015 (at pages 1-2 of the FtT bundle). He also placed reliance upon the medical evidence in the supplementary bundle together with that of Ms Cross given orally.

20. He submitted that the evidence was that C1 and C2 (age 3½ and 2½ respectively) suffered from an inherited metabolic disorder, CDG1a. He invited me to accept the medical evidence of Dr Chronopoulou, a Paediatric Metabolic Consultant at University Hospitals Bristol in his report dated 4 March 2016 (at pages 4-5 of the supplementary bundle) and Dr Pierre also a Paediatric Metabolic Consultant at the Bristol Hospital in her report dated 4 March 2016 (at pages 6-9 of the supplementary bundle). That evidence, Mr Ahmed submitted, demonstrated that the inherited condition of C1 and C2 required specialist care as was provided at the Bristol Hospital. Mr Ahmed emphasised the specialist nature of the care and management required for the metabolic disorder suffered by C1 and C2 and reminded me of the evidence of Ms Cross that there was a need for more extensive intensive treatment and care given the complications that may arise even for conditions which might otherwise be relatively straightforward if the individual did not suffer from CDG1a. He relied on the conclusion of the two consultants that without this level of intensive medical surveillance and management there was, in the words of Dr Pierre: "risk of significant morbidity or even death".

21. Mr Ahmed submitted that given the consequences to C1 and C2 of their inherited disorder in the absence of appropriate specialist care, it would be disproportionate to remove them to Pakistan. Mr Ahmed referred me to, and relied upon, the Court of Appeal's decision in MM (Zimbabwe) v SSHD [2012] EWCA Civ 279 and the Upper Tribunal's decision in Akhalu (Health Claim: ECHR Article 8) Nigeria [2013] UKUT 00400 (IAC). He submitted that the availability of treatment was a relevant factor in assessing proportionality. He accepted that, in the light of GS (India) and Others v SSHD [2015] EWCA Civ 400 that C1 and C2's medical condition was not a 'trump card'. He invited me to take into account that the appellant had previously had difficulties in caring for the children and that there had been social services intervention. He accepted that I should apply the factors set out in s.117B of the NIA Act 2002, but, he submitted, it must be contrary to the public interest to return C1 and C2 to Pakistan where they would have no treatment.

22. Mr Ahmed relied upon the Court of Appeal's decision in R (SQ) (Pakistan) and Another v UTIAC and Another [2013] EWCA Civ 1251 where, in a case concerned with Article 8 and a health claim by a child, the Court of Appeal had remitted the case to the Upper Tribunal where the needed medical treatment had been available albeit that access to it was not without some difficulty. Mr Ahmed also pointed out that in that case the children had come to the UK with health conditions whilst in the current appeal C1 and C2 had been born in the UK. He submitted that C1 and C2 should not be blamed for their parent's action in coming to the UK and remaining without lawful status.

23. Mr Ahmed submitted in conclusion that this was one of the few or rare cases where the public interest was outweighed by the impact upon the health of C1 and C2 of return to their own country and amounted to a breach of Article 8.

24. In the respondent's written submissions, adopted whole-scale by Mr Richards as the Secretary of State's submissions, it is accepted that C1 and C2 suffer from an incurable genetic disorder, namely CDG1a and that this involves regular medical care and assistance for the rest of their lives. Further, it is accepted that C1 and C2 are in receipt of medication and various treatments through care provided in the NHS. It is accepted that the prognosis for both children requires constant help and support for life or for the foreseeable future. Whilst it is not expressly conceded that the required level of medical assistance and care in Pakistan is not available, Mr Richards did not seek to argue that medical care of the type and intensity required for C1 andC2's condition in the UK was available in Pakistan.

25. The Secretary of State acknowledges that the appellant does not seek to rely on Article 3 and that, therefore, the 'high threshold' required in a health case to succeed under Article 3 is accepted as not met by the appellant. Likewise, it is not suggested that the appellant can meet any of the requirements of the Immigration Rules.

26. The Secretary of State submits that the best interests of all four of the appellant's children are to remain with their mother.

27. As regards Article 8, the Secretary of State submits that the appellant has no family or private life in the UK. Further, her relationship and the birth of her children occurred when her asylum claim had failed and she had no leave to remain. It is submitted that "the facts reveal no engagement of Article 8".

28. In respect of proportionality, the Secretary of State submits that the public interest outweighs the interests of the family, including C1 and C2. It is submitted that the appellant have family members in Pakistan who could assist and support her and the two children. It is submitted that the public interest is readily identified in the fact that neither the appellant nor her children have leave to remain. The family are reliant on benefits for their support including suitable present and future reliance on NHS treatment required by C1 and C2.

29. The respondent cites the case law in MM, GS and Others, and Akhalu. The Secretary of State submits that given that the family would be returned to Pakistan together Article 8 family life is not engaged for the purposes of a proportionality exercise. As regards the appellant's private life she has only been in the UK pursuing her claim for asylum which, has been rejected, and the relationship that she entered into was forged at a time when neither parties had leave to remain in the UK and she has shown little evidence of private life outside that of the pursuit of her claim to remain in the UK. On the basis of the case law, the Secretary of State submits that the appellant cannot succeed under Article 8 of the ECHR.

The Legal Framework

30. The appellant relies exclusively upon Article 8 of the ECHR which provides as follows:

> "Article 8
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others"

31. The burden of proof is upon the appellant to establish that there are substantial grounds for believing that if returned to Pakistan there is a real risk of a breach of Article 8. The burden is upon the Secretary of State to justify any interference with the appellant's right to respect for her private and family life under Article 8.2.

32. In applying Article 8, the five stage test set out in the opinion of Lord Bingham of Cornhill in R (Razgar) v SSHD [2004] UKUT 27 at [17] is as follows:

> "(1) Will the proposed removal be an interference by a public authority with the exercise of the applicant's right to respect for his private or (as the case maybe) family life?
>
> (2) If so, will such interference have consequences of such gravity as potentially to engage the operation of Article 8?
>
> (3) If so, is such interference in accordance with the law?
>
> (4) If so, is such interference necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others?
>
> (5) If so, is such interference proportionate to the legitimate public end sought to be achieved?"

33. At [20], as regards the issue of proportionality, Lord Bingham said this:

> "[it] always involves(s) the striking of a fair balance between the rights of the individual and the interests of the community which is inherent in the whole of the Convention. The severity and consequences of the interference will call for a careful assessment at this stage. "

34. In this appeal, the appellant does not argue that she can succeed under the Immigration Rules. As a consequence, the appellant must establish that there are "compelling" circumstances such that her removal would be disproportionate (see Khalid and Singh v SSHD [2015] EWCA Civ 74).

35. In determining whether there is a breach of Article 8 in this appeal, by virtue of s.117A(2) I must have regard to the factors set out in s.117B of the NIA Act 2002 in determining the "public interest question", i.e proportionality, under Art 8.2:

> **"117B Article 8: public interest considerations applicable in all cases**
>
> (1) The maintenance of effective immigration controls is in the public interest.
>
> (2) It is in the public interest, and in particular in the interests of the economic well-being of the United Kingdom, that persons who seek to enter or remain in the United Kingdom are able to speak English, because persons who can speak English—
>
> (a) are less of a burden on taxpayers, and
>
> (b) are better able to integrate into society.
>
> (3) It is in the public interest, and in particular in the interests of the economic well-being of the United Kingdom, that persons who seek to enter or remain in the United Kingdom are financially independent, because such persons—
>
> (a) are not a burden on taxpayers, and
>
> (b) are better able to integrate into society.
>
> (4) Little weight should be given to—
>
> (a) a private life, or
>
> (b) a relationship formed with a qualifying partner, that is established by a person at a time when the person is in the United Kingdom unlawfully.
>
> (5) Little weight should be given to a private life established by a person at a time when the person's immigration status is precarious.
>
> (6) In the case of a person who is not liable to deportation, the public interest does not require the person's removal where—
>
> (a) the person has a genuine and subsisting parental relationship with a qualifying child, and
>
> (b) it would not be reasonable to expect the child to leave the United Kingdom."

36. Further, I must have regard not only to the rights of the appellant but also the rights of the appellant's children, particularly C1 and C2 (see Beoku-Betts v SSHD [2008] UKHL 39).

37. In that regard the 'best interests' of C1 and C2 are a "primary consideration" (see ZN (Tanzania) v SSHD [2011] UKSC 4). Although a primary consideration,, the best interests of a child are not necessarily determinative of the issue of proportionality since those interests can be outweighed by sufficiently strong or weighty considerations of the public interest

38. In Zoumbas v SSHD [2013] UKSC 74, the Supreme Court summarised the applicable principles as follows (at [10]):

> "(1) The best interests of a child are an integral part of the proportionality assessment under article 8 ECHR;
>
> (2) In making that assessment, the best interests of a child must be a primary consideration, although not always the only primary consideration; and the child's best interests do not of themselves have the status of the paramount consideration;
>
> (3) Although the best interests of a child can be outweighed by the cumulative effect of other considerations, no other consideration can be treated as inherently more significant;
>
> (4) While different judges might approach the question of the best interests of a child in different ways, it is important to ask oneself the right questions in an orderly manner in order to avoid the risk that the best interests of a child might be undervalued when other important considerations were in play;
>
> (5) It is important to have a clear idea of a child's circumstances and of what is in a child's best interests before one asks oneself whether those interests are outweighed by the force of other considerations;
>
> (6) To that end there is no substitute for a careful examination of all relevant factors when the interests of a child are involved in an article 8 assessment; and
>
> (7) A child must not be blamed for matters for which he or she is not responsible, such as the conduct of a parent".

39. It is not contended by the appellant that she can succeed under Article 3 of the ECHR in this appeal on the basis of the jurisprudence dealing with Article 3 claims in 'health' cases. Those are cases where the whole or an integral part, of an individual's claim to remain in the UK is that they will receive (substantially) less favourable health care or medical treatment in the country to which they will be returned. Both the case law of the Strasbourg Court and of the domestic courts imposes a "very high" hurdle, attainable only in wholly exceptional circumstances in such cases (see D v UK (1997) 24 EHRR 423; N v SSHD [2004] 2 AC 296 and N v UK (2008) 47 EHRR 39).

40. In MM (Zimbabwe) v SSHD [2012] EWCA Civ 279, Moses LJ identified the essential principle from the case law as follows at [17]:

> "The essential principle is that the ECHR does not impose any obligations on the contracting states to provide those liable to deportation with medical treatment lacking in their 'home countries'. This principle applies even where the consequence will be that the deportee's life will be significantly shortened…."

41. The case law, nevertheless, recognises that a 'health' case may succeed under Article 8 even where it would fail under Article 3 of the ECHR (see Bensaid v UK (2001) 33 EHRR 10 at [46]). The potential health consequences for an individual would engage

that aspect of his or her private life covered by the rubric of "the physical and psychological integrity of [the] person" (see Pretty v UK (2002) 35 EHRR 1 at [61]).

42. In Razgar, Baroness Hale considered the application of Article 8 in 'health' cases. Having referred to Bensaid at [56], at [459] Lady Hale noted that:

> "Although the possibility cannot be excluded, it is not easy to think of a foreign healthcare case which would fail under Art 3 but succeed under Art 8. There clearly must be a strong case before the article is even engaged and then a fair balance must be struck under Art 8(2). In striking that balance, only the most compelling humanitarian considerations are likely to prevail over the legitimate aims of immigration control or public safety. The expelling state is required to assess the strength of the threat and strike that balance. It is not required to compare the adequacies of the healthcare available in the two countries. The question is whether removal to the foreign country will have a sufficiently adverse affect upon the applicant."

43. In these cases, whilst the potential application of Article 8 is recognised, nevertheless the courts acknowledge that in a 'health' case it will be difficult nevertheless to succeed under Article 8 either because of the significant threshold to engage Article 8 or, if it is engaged, for the circumstances of the individual to be such as to outweigh the public interest.

44. In Akhalu, the Upper Tribunal, having analysed the relevant case law including Bensaid, MM (Zimbabwe), and GS and EO in the Upper Tribunal, concluded at [43]:

> "The correct approach is not to leave out of account what is, by any view, a material consideration of central importance to the individual concerned but to recognise that the counter-veiling public interest in removal will outweigh the consequences with the health of the claimant because of a disparity of healthcare facilities in all but a very few cases."

45. In Akhalu the Upper Tribunal endorsed a holistic approach to proportionality such that regard may be taken of the disparity in health resources but concluded that any such disparity did "not weigh heavily" in an individual's favour but rather spoke "cogently in support of the public interest in removal" (see [45]-[46]).

46. In GS and Others, the Court of Appeal returned to the question of the scope for reliance upon Article 8 in 'health' cases. In his judgment, Laws LJ acknowledged the limited prospect of success under Article 8, when an Article 3 claim fails, because of the "no obligation to treat" principle recognised in the authorities. At [86]-[87], Laws LJ referring to the earlier decision in MM, said this:

> "86. If the Article 3 claim fails (as I would hold it does here), Article 8 cannot prosper without some separate or additional factual element which brings the case within the Article 8 paradigm – the capacity to form and enjoy relationships – or a state of affairs having some affinity with the paradigm. That approach was, as it seems to me, applied by Moses LJ (with whom McFarlane LJ and the Master of the Rolls agreed) in *MM (Zimbabwe)* [2012] EWCA Civ 279 at paragraph 23:
>
> > "The only cases I can foresee where the absence of adequate medical treatment in the country to which a person is to be deported will be

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

87. With great respect this seems to me to be entirely right. It means that a specific case has to be made under Article 8. It is to be noted that *MM (Zimbabwe)* also shows that the rigour of the D exception for the purpose of Article 3 in such cases as these applies with no less force when the claim is put under Article 8:

> "17. The essential principle is that the ECHR does not impose any obligation on the contracting states to provide those liable to deportation with medical treatment lacking in their "home countries". This principle applies even where the consequence will be that the deportee's life will be significantly shortened (see Lord Nicholls in N v Home Secretary [2005] 2 AC 296, 304 [15] and N v UK [2008] 47 EHRR 885 (paragraph 44)).
>
> 18. Although that principle was expressed in those cases in relation to Article 3, it is a principle which must apply to Article 8. It makes no sense to refuse to recognise a 'medical care' obligation in relation to Article 3, but to acknowledge it in relation to Article 8."

47. In his judgment Underhill LJ also dealt with Article 8 and its application in 'health' cases. At [108] with reference to Razgar and Bensaid, Underhill LJ accepted that a decision to remove an individual which would prejudice access to medical treatment "may in principle engage Article 8" (see also [109]). Underhill LJ went on to consider how Article 8 could be applied in the light of the "no obligation to treat" principle. At [110]-[111] he analysed the case law, including the earlier decision in MM, as follows:

> "110. However, that raises the question of how, if article 8 is indeed potentially engaged in cases of this kind, that is reconcilable with the principle established in relation to article 3 that a member state is under no obligation to permit a person to remain for the purpose of obtaining medical treatment not available in the country of return. In enunciating that principle in *N* neither the House of Lords nor the Strasbourg Court reviewed its relationship with the potential engagement of article 8 as established in *Bensaid* or *Razgar*: that is indeed one of the criticisms made in the judgment of the minority in Strasbourg in N – see para.)-126 (pp. 911-2).
>
> 111. It is that question which this Court addressed in *MM (Zimbabwe)*. Moses LJ with whom the other members of the Court agreed, held that the "no obligation to treat" principle must apply equally in the context of article 8:

> see paras. 17-18 of his judgment, which Laws LJ sets out at para. 89 above. He then sought to identify what courts in the United Kingdom have declined to say that Article 8 can never be engaged by the health consequences of removal from the United Kingdom", referring to *Razgar* and also to *AJ (Liberia) v Secretary of State for the Home Department* [2006] EWCA Civ 1736 (another mental health case); but he drew attention to statements in both cases emphasising how exceptional the circumstances would have to be before a breach were established. In particular, he set out, at para. 20, a passage to that effect from the opinion of Lady Hale in *Razgar* which starts with the observation that "it is not easy to think of a foreign health care case which would fail under Article 3 but succeed under Article 8". He concluded, at para. 23 with a passage which Laws LJ has already quoted but which for ease of reference I will set out again:
>
> > "the only cases I can foresee where the absence of adequate medical treatment in the country to which a person is to be deported will be relevant to Article 8, is where it is an additional factor to be weighed in the balance, with other factors which by themselves engage Article 8. Suppose, in this case, the appellant had established firm family ties in this country, then the availability of continuing medical treatment here, coupled with his dependence on the family here for support, together establish 'private life' under Article 8. That conclusion would not involve a comparison between medical facilities here and those in Zimbabwe. Such a finding would not offend the principle expressed above that the United Kingdom is under no Convention obligation to provide medical treatment here when it is not available in the country to which the appellant is to be deported."
>
> There are possibly some ambiguities in the details of the reasoning in that passage, but I think it is clear that two essential points are being made. First, the absence or inadequacy of medical treatment, even life-preserving treatment, in the country of return, cannot be relied on at all as a factor engaging article 8: if that is all there is, the claim must fail. Secondly, where article 8 is engaged by other factors, the fact that the claimant is receiving medical treatment in this country which may not be available in the country of return may be a factor in the proportionality exercise; but that factor cannot be treated as by itself giving rise to a breach since that would contravene the "no obligation to treat" principle."

48. At [111], Underhill LJ (with whom Sullivan LJ agreed) identified that a disparity in medical treatment or care could not, in itself, engage Article 8. However, applying what was said in MM and subsequently by the Upper Tribunal in Akhalu, he recognised that if other factors engaged Article 8 then the availability of treatment was a factor in the proportionality exercise but, importantly, acknowledged that a disparity in medical treatment could not in itself give rise to a breach of Article 8 because of the "no obligation to treat" principle.

49. Working that approach out at [114], Underhill LJ concluded in relation to one of the cases before the Court of Appeal that the individual's claim under Article 8 based upon interference with private life in the UK could not succeed. Turning to the disparity in health care, Underhill LJ concluded:

> "In those circumstances, to strike the Article 8 balance in his favour only because of the consequences for his health if he were treated, however grave, would be in substance to impose an obligation to treat."

50. Mr Ahmed relied upon the case of SQ (Pakistan) which concerned a child. That case concerned a child who suffered from Beta Thalassaemia, a very serious genetic condition for which he required treatment. The evidence was that, although healthcare was available in Pakistan, it was of a significantly lower quality than that available in the UK. The applicant has failed in his Article 8 claim before the First-tier Tribunal and had been refused leave to appeal by the Upper Tribunal. The Court of Appeal was concerned with a judicial review challenge (a Cart challenge) to that refusal of permission to appeal. The Court of appeal concluded that the FtT had wrongly excluded "health consideration and the discontinuance of the UK treatment" in assessing the child's best interest (see [24]). As a consequence, the Court of Appeal remitted the case to the Upper Tribunal for a rehearing. In doing so, Maurice Kay LJ (with whom Lewison and Underhill LJJ agreed) said this at [26]-[27]:

> "26. What this case demonstrates is that in some cases, particularly but not only in relation to children, Article 8 may raise issues separate from Article 3. In JA (Ivory Coast) v Secretary of State for the Home Department [2009 EWCA Civ 1353, an adult succeeded under Article 8 (but not Article 3) in a health case. Sedley LJ emphasised (at paragraph 17) that each of the two Articles "has to be approached and applied in its own terms". The leading authorities of D and N were distinguishable on the basis that, in both of them, the appellants' presence and treatment in this country "were owed entirely to unlawful entry". JA's appeal was allowed and her case remitted because of the potential significance of the fact that, following her lawful entry and subsequent diagnosis of HIV+, she had been granted further exceptional leave to remain for treatment. Although no separate Article 8 issue arose in D or N, it plainly did in JA.
>
> 27. I do not intend to predict or seek to influence the outcome of the present case on remittal. On the one hand, MQ can prey in aid his lawful entry and his status as a child with the protection of the ZH approach. On the other hand, he arrived with his serious medical conditions at an advance stage and, although not an unlawful entrant, it will be relevant to consider whether his arrival here was a manifestation of "health tourism". If it was, that would fall to be weighed in the balance. After all, this country is under no international obligation always to act as "the hospital of the world". The difficult question is whether it would be disproportionate to remove this child in the light of all the evidence in the case, including the medical evidence which, at present, is not as clearly presented as it could be."

51. As [27] makes plain, the Court of Appeal, whilst recognising the potential application of Article 8 to that applicant, nevertheless was not persuaded that the claim was bound either to succeed or to be lost (see also [25]). The matter was properly to be determined by the Upper Tribunal on the basis of all the evidence. Nevertheless, SQ (Pakistan) illustrates that in a 'health' case, Article 8 may have (greater) purchase where the applicant is a child.

52. That approach was followed in the more recent decision of the Court of Appeal in AE (Algeria) v SSHD [2014] EWCA Civ 653. That case involved an individual who had a six year old daughter with spina bifida which resulted in her being very severely disabled, with severe learning difficulties and extremely complex needs (see [1]). There, also, the Court of Appeal remitted the appeal to the Upper Tribunal to consider the application of Article 8 on the basis that the Upper Tribunal had failed properly to consider the child's best interests. At [9], Maurice Kay LJ (with whom Black and Lewison LJJ agreed) said this:

> "What was required was a structured approach with the best interests of [M] and her siblings as a primary consideration but with careful consideration also of factors pointing the other way. Such factors include but are not limited to the over-staying of the children and their mother and the illegal entry and bogus asylum claim of the appellant father. The latter is no doubt what the UT had in mind when referring to 'the need to maintain immigration control'. Moreover, I do not consider that it would be inappropriate for the future cost and duration of [M's] treatment and care in this country to play a part in the balancing exercise as matters relating to the economic well being of this country, given the strains on the public purses."

53. Again, the Court of Appeal remitted the appeal to the Upper Tribunal as the "outcome is not self-evident" (see [9]).

54. The decisions in SQ and AE represent no more than an application of the "best interests" jurisprudence as summarised in Zoumbas above. Whilst the circumstances of a child may (though not must) more readily engage Article 8.1, in assessing proportionality and taking into account as a "primary consideration" a child's best interests, the public interest remains to be weighed bearing in mind the clear steer of the Strasbourg and domestic courts that, even under Article 8, the public interest reflected in the economic well-being of the country remains a powerful and weighty factor in 'health' or 'welfare' cases. As the Court of Appeal in GS and others recognised, the Convention imposes no obligation upon a contracting state to provide medical treatment or healthcare (including social care for the purposes of this appeal) when it is not available (or not so well provided) in the country to which the individual is to be removed and so it will only be in a "truly exceptional" or "very rare case" where the public will be outweighed by the individual's circumstances even where that individual is a child.

55. It is noteworthy that in GS and Others Underhill LJ, having referred to AE (Algeria) and SQ (Pakistan) (in which he was one of the constitution of the court), did not consider that the child cases fell outside the general approach to 'health' cases under Art 8 (at [109]):

> "The latter two cases concern children, but I do not see that that can make any difference in principle."

56. I now turn to consider the evidence and to make findings in relation to the legal framework of Article 8.

Discussion and Findings

57. I make the following findings having taken into account the documentary and other evidence to which I was referred and applying the legal principles and framework which I have set out above.

58. I deal first with the evidence concerning C1 and C2's health. The evidence concerning their inherited metabolic disorder was not in dispute. The circumstances are helpfully set out in the report of Dr Pierre dated 4 March 2016 (at pages 8-9 of the supplementary bundle) as follows:

> "C1 DOB 10/07/2012 and C2 DOB 01/11/2013 have an extremely rare inherited metabolic disorder called Congenital Disorder of Glycosylation type 1a (CDG1A) or Phosphomannomutase 2 Deficiency and are under the care of the South West Regional Metabolic department. C1 has been under my care since August 2013 and his brother C2 since his birth in November 2013.
>
> The diagnosis of CDG1a belongs to a group of disorders where there is abnormal linking of sugars on to proteins in compounds in the body called glycoproteins or glycolipids. Glycoproteins and glycolipids are important for signalling and transmitting information from one part of the body to another. Problems in these processes lead to dysfunction in many organ systems and patients with CDG1a have multisystem disease which can lead to serious complications. Very few doctors have the knowledge about this disorder. In England there are six specialist paediatric centres that see about the care of these patients and most clinicians are unfamiliar with the disease. Care under a specialist team is needed to avoid complications which may result in death or significant morbidity. Specialist care for CDG1a also includes the multidisciplinary involvement of other teams including renal, neurology, cardiology and community paediatrics.
>
> C1 already has many problems typically seen in patients with CDG1a including, low muscle tone, developmental delay, clotting problems, liver dysfunction, renal problems, squinting and feeding difficulties with poor weight gain. His brother C2 was diagnosed at a few months of age but is likely to have similar problems.
>
> Patients have specialist care in the management and/or prevention of the following complications
>
> - Failure to thrive
> - Stroke like episodes
> - Clotting problems
> - Seizures
> - Life threatening complications during illness
>
> **Failure to thrive**. Patients have difficulty gaining weight which if untreated may lead to malnutrition. C1 is currently receiving high caloric supplements because of weight loss. Both C1 and C2's weight will be closely regulated. Persistent vomiting can develop requiring gastroenterology input. If necessary a stomach tube will be inserted for nutritional support or because swallowing is unsafe.

> **Stroke Like Episodes**. The problems with clotting increase the risk of recurrent strokes in these patients. Specialist management of fluids with early supportive intravenous fluid therapy and if necessary physiotherapy prevents permanent dysfunction or death and usually leads to full recovery over days or months.
>
> **Clotting Problems**. Management of the abnormal coagulation is also needed for any surgical procedure with collaboration of haematology and surgery. Infusions of fresh frozen plasma may be needed to prevent bleeding. Later patients are at risk of deep venous thrombosis so may need anticoagulation.
>
> **Seizures**. Patients may develop seizures or epilepsy. It is very important that they receive antiepileptic medication to manage this. In a few cases patients may develop such difficult to control seizures that a specialist diet called the ketogenic diet is indicated. This again needs to be from a trained metabolic or trained neurology deititian.
>
> **Life threatening complications during illness**. In particular during infancy and early childhood, patients with CDG1a have a lower physiologic reserve than their peers and become more unwell. This can sometimes lead to a catastrophic phase presenting with infection, seizure or, hypoalbuminemia with third spacing. Aggressive early management with albumin replacement in a specialist hospital is needed. Early review by the specialist team with aggressive management of prolonged fever, vomiting, or diarrhoea can help prevent the severe illness associated with this 'infantile catastrophic phase". Both C1 and C2 have an emergency management plan to be followed if they should present to hospital. It also includes the contact details of the specialist metabolic team to give further advice about management."

59. Dr Pierre concludes her report with a section headed "Prognosis" in which she deals with the availability (or more accurately, lack of availability) of the care required by C1 and C2 in Pakistan as follows:

> "**Prognosis**. As a result of the complications that can occur without specialist knowledge in patients with CDG1a, it is important that patients remain under specialist care all of their life with transition to the adult metabolic services when they are older. **I am very concerned that the lack of the availability of this level of intensive medical surveillance and specialist management in Pakistan with place C1 and C2 at risk of significant morbidity or even death.**"

60. The substance of that report is mirrored in the report of Dr Chronopoulou dated 4 March 2016 (at pages 4-5 of the supplementary bundle). In his report Dr Chronopoulou, having set out C1 and C2's condition and the care required in the UK, states that:

> "This care would not be available to the boys in Pakistan."

61. Again, later in his report, referring to the specialist care required for their lifetime he states:

> "This specialist care is not available in Pakistan."

62. In her oral evidence, Ms Cross was asked how the doctors were aware that the intensive treatment and continued care required for C1 and C2 was not available in Pakistan. Her response was that metabolic disorders are rare and that doctors'

network on an international scale and generally know where teams are. She said that in Pakistan care was definitely not available. In her evidence she also explained that the specialist care by a 'metabolic team' was important because of the "greater knowledge of what complications may arise" from illnesses developed by the children.

63. I also note that there is a witness statement from a caseworker at the appellant's solicitors dated 7 March 2016 (at page 1 of the supplementary bundle) which states that she has undertaken research over the internet concerning the availability of treatment for CDG in Pakistan and:

> "I was unable to find any treatment that is available for CDG in Pakistan".

64. The medical evidence comes from specialists and experts in their field who have dealt with and had the care of C1 and C2. I have no hesitation in accepting it and was not in substance challenged before me. I accept, therefore, not only the fact that C1 and C2 have an inherited metabolic disorder known as CDG1a but also that they require specialist management and care which is not available to them in Pakistan. They have both experienced a variety of medical difficulties during their short lives which have required treatment by a specialised team. Their need for care is frequent and regular. I accept that, in its absence, there is a risk of "significant morbidity or even death" in the future.

65. Turning to the appellant's health, she gave evidence that she was taking medication for depression and that she was visited by a woman every week or two to provide support. Mr Ahmed referred me to a report from Dr Clarke (at pages 3-5 of the FtT bundle) together with a number of other documents which indicate that the appellant has suffered mental health problems because of post-natal depression and received psychiatric support and care. At one point, a referral was made to social services and for mental health services in July 2012 (and again in 2013 and 2014) because of the post-natal depression and concern that the appellant was a risk to her children.

66. Mr Ahmed did not direct my attention to any up to date evidence concerning the appellant's mental health. There appears to be no up-to-date evidence on her mental health contained in the FtT bundle. The supplementary bundle is concerned only with C1 and C2's condition. For present purposes, I accept the history I have just described and that the appellant continues to receive medication and support for depression. There is also some evidence, but not it would appear formally diagnosed, that the appellant has symptoms "suggestive of PTSD" (see Dr Clark's report at pp3 and 4 of the FtT bundle). Mr Ahmed did not specifically rely upon the appellant's mental health problems, in particular any risk of committing suicide on return, as a basis for her claim.

67. The appellant's psychiatric condition is considered at length in the decision letter of 20 January 2014 at paras 18-26. Mr Ahmed did not suggest that the respondent's decision letter was wrong to state (at para 22) the position in 2013 (nor did he suggest that it had changed subsequently) as follows:

> "The Home Office notes that the latest Country of Origin Information Report (COIR) on Pakistan (dated August 2013) records that there is treatment for mental health disorders, such as anxiety and depression, and so forth, as part of the primary health care infrastructure; including the provision of treatment in psychiatric and mental health hospitals."

68. I see no basis for concluding, particularly given the focus of the appellant's submissions, that there is real risk that she will commit suicide if returned to Pakistan. Further, and this stands unchallenged by the appellant, the background evidence shows the availability of treatments for mental health including depression in Pakistan. I do not accept, therefore, that she will be unable to obtain treatment needed for her own condition.

69. Turning now to other matters, Mr Ahmed told me about the appellant's background and a little (but not a great deal) about that of her two older children. The appellant has been in the UK since 14 May 2011 initially with leave as a visitor until 11 April 2013 but that was curtailed by the decision of 6 January 2012. Her leave consequently expired on 8 November 2012 when she became appeal rights exhausted.

70. The appellant travelled to the UK with her two elder children whom she told me, in her oral evidence, were 8 years old and 6 years old. In the UK she formed a relationship with a Pakistani citizen whom she had previously known. Their children, C1 and C2, were born on 10 July 2012 and 1 November 2013 respectively. Both have, as I have already noted, an inherited metabolic disorder, CDG1a. Both children have been in receipt of care and treatment in relation to that condition since 2013.

71. I was not shown (nor am I aware of) any evidence concerning any continuing relationship between the appellant and C1 and C2's father in the UK. Certainly in earlier proceedings it was clear that he and the appellant, although they had previously lived together, no longer did so (see para 28 of Judge Lloyd's determination). The appellant's earlier evidence was that she considered the relationship to continue despite them not living together. There is also an absence of any current evidence concerning the relationship between C1 and C2 and their father. Mr Ahmed did not address me on this aspect of the appellant's claim. Given the earlier evidence, I am content to accept that the relationships continue between the appellant, C1 and C2 and their partner/father.

72. Whilst I accept that the appellant and her four children (and her partner/their father) enjoy family life together, there is no suggestion that the children will other than travel with the appellant to Pakistan and if he wishes to do so could the father of C1 and C2 given, what I understand to be the position, his lack of immigration status in the UK. Consequently, the removal of the appellant will not interfere with the family life enjoyed by the family as a whole.

73. That said, however, I accept that the appellant has established private life in the UK during the almost five years of her residence here despite the fact that she has not

been here lawfully since November 2012. Although I was not directed to any material specifically dealing with the appellant's two older children, aged 8 and 6 respectively, Mr Richards did not suggest that they did not have private life in the UK and, given their age, they attend school and I am satisfied that they also have private life in the UK which will be interfered with if returned to Pakistan.

74. C1 and C2 are both very young and their lives are focussed on their mother at present. I was not shown any evidence suggesting they had any significant private life outside their relationships in the home. However, I further accept, given the absence of treatment for C1 and C2 in Pakistan, that their private life in the UK, taken together with the impact upon their health if returned to Pakistan, amounts to an interference with their private life.

75. For these reasons, I am satisfied that Article 8.1 is engaged.

76. The central issue in this appeal is whether that interference is justified under Article 8.2. There is no doubt that the interference is in accordance with the law and for a legitimate aim, namely the economic well-being of the country or in order to prevent disorder or crime (see Shahzad (Art 8: Legitimate Aim) Pakistan [2014] 0085 (IAC)). The crucial issue is that of proportionality.

77. First, Even though the older children have been in the UK for 5 years, I accept the respondent's contention that the best interests of all four children (ignoring for present purposes the impact upon the health of C1 and C2) is to be with the appellant whether she is in the UK or, if removed, in Pakistan. The older children were, of course, born in Pakistan and are citizens of Pakistan. It was not advanced before me by Mr Ahmed that the older children could not obtain an adequate education in Pakistan or could not integrate there culturally and socially where the appellant has family and their father lives.

78. Secondly, however, I accept that when regard is had to the effect of removal on the health of C1 and C2, because of the risk of serious impact upon their health because of the lack of specialist care for their genetic condition, it is not in their best interests to leave the UK and live in Pakistan.

79. Thirdly, the appellant and her children have no lawful basis for being in the UK. The leave of the appellant (and as I understand it of her older children also) expired in November 2012. It does not appear that C1 and C2 have ever had leave to remain in the UK – although given their age that is not something for which they can be responsible. Likewise, again as I understand it, the appellant's partner has no lawful basis for being in the UK.

80. Fourthly, I accept that the appellant did not come to the UK in order to obtain medical treatment for C1 and C2. They were, of course, born in the UK subsequent to her arrival and there is no evidence that the appellant was aware of the potential for them inheriting the metabolic disorder, CDG1a before she came to the UK.

81. Fifthly, I accept that the immigration status of the appellant should not necessarily reflect upon the children.

82. Sixthly, it is clear from the case law that a breach of Article 8 cannot be established simply on the basis of a disparity in health provided in the UK and in the appellant's own country. It will only be in a "very rare" case that the public interest in the economic well-being of the country will be outweighed by an individual's interest, (whether that of a child or adult) where the central part of their claim is the disparity in the provision of those services.

83. Seventhly, given the immigration status of the appellant and, indeed, the children including C1 and C2, the maintenance of effective immigration control is in the public interest (see s.117B(1) of NIA Act 2002).

84. Eighthly, although I was not told about the linguistic competence in English of the appellant and (at least) her elder children, the appellant did give her evidence through an interpreter and, therefore, to that extent at least the public interest set out in s.117B(2) that it is in the economic well-being of the UK that an individual should speak English is engaged.

85. Ninthly, there was no evidence that the appellant was financially independent. In any event, in relation to C1 and C2 (and also the appellant herself and her mental health problems) they remain a financial burden on the public purse because of their need for NHS care from a specialist unit. In AE (Algeria) at [9] Maurice Kay LJ pointed out that it would not be:

> "inappropriate for the future cost and duration of [the child's] treatment and care in the country to play a part in the balancing exercise as matters relating to the economic well-being of this country given the strains of the public finances."

86. The burden an individual may impose on the public purse was also recognised as an important aspect of the public interest in the economic well-being of the country by Sir Stanley Burnton in FK and OK (Botswana) v SSHD [2013] EWCA Civ 238 at [11]. There is no doubt, that C1 and C2's presence in the UK will impose a significant burden upon public resources in the NHS. There will also be a burden in relation to their (and their siblings) educational provision.

87. As the Court of Appeal made clear in GS and Others an holistic approach is required in relation to proportionality but, in determining the issue of proportionality, the disparity in medical treatment between the UK and, in this case, Pakistan can be a factor but cannot in itself give rise to a breach of Article 8 otherwise it would contravene the "no obligation to treat" principle.

88. Finally, the appellant's private life is entitled to "little weight" in the proportionality assessment as it was established whilst she was here unlawfully (see s.117B(4)) or whilst her immigration status was "precarious" in that her initial leave was as a visitor (see s.117B(5)).

89. Given the fact that the appellant has only been in the UK for just under five years but has had no lawful leave since November 2012, having regard to the best interests of her children as a primary consideration, without having regard to the impact upon C1 and C2's health, there is nothing "compelling" in the appellant's circumstances and I am in no doubt that it would be proportionate to remove her to Pakistan. It was not suggested by Mr Ahmed that there was any reason why she could not travel to Pakistan apart from the health consequences of C1 and C2. Her asylum claim based upon domestic violence from her husband and family has not been accepted and established as a basis for her non-return. That is no longer challenged or relied upon.

90. As I have already said, the impact upon C1 and C2 of returning to Pakistan, given their inherited metabolic disorder of CDG1a is set out in the medical reports, in particular that of Dr Pierre above. I accept that the intensive medical management and care required for that condition is not available in Pakistan and, as the expert evidence states, then there is the risk of "significant morbidity or even death" for C1 and C2 on return. If, however, the Article 8 balance was struck in the appellant's favour only because of the consequences to the health of C1 and C2 if the appellant were removed, however serious those consequences might be, would be in effect to impose an obligation to treat in contravention of the established and consistent case law (see, for example Underhill LJ at [114] in GS and Others).

91. It is not contended that the impact upon C1 and C2 reaches the "high threshold" establishing a breach of Article 3 based upon the disparity in available health care to C1 and C2. C1 and C2 are children, and therefore heighten the humanitarian concerns of any decision maker. However, there is no principled difference between cases of adults and children as Underhill LJ made plain in GS and Others at [109]. Whilst I accept that a case may succeed under Article 8 even though the high threshold for Article 3 is not reached, this is not, in my judgement, one of those rare cases which fall into that exceptional category. The public interest, as I have identified, is strong in this appeal. The impact upon the NHS resources will be significant if C1 and C2 remain in the UK requiring, in effect, life-long care. It remains an underlying premise of the Strasbourg and domestic case law that the Convention does not impose upon a state an obligation to treat an individual simply on the basis of a disparity of treatment even if the consequence to the individual may or will be life-threatening. The position of the appellant and her children, C1 and C2 naturally invokes empathy from any reasonable person. However, that is not sufficient to establish a breach of the Convention (as is accepted) under Article 3 or in striking a fair balance between the public interest and the individuals' circumstances under Art 8.2. Carrying out the required balancing exercise, in my judgment, despite the health implications for C1 and C2, the public interest outweigh the rights and interests of the appellant and her children including C1 and C2.

92. For these reasons, I am not satisfied that the appellant has established a breach of Article 8 of the ECHR.

Decision

93. The First-tier Tribunal's decision to dismiss the appellant's appeal on asylum and humanitarian protection grounds stands.

94. The First-tier Tribunal's decision to allow the appellant's appeal under Article 8 involved the making of an error of law and was set aside by the decision of the Upper Tribunal dated 10 July 2015.

95. I remake the decision in respect of Article 8 and dismiss the appellant's appeal on that ground also.

Signed

A Grubb
Judge of the Upper Tribunal

Date: