Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: HU/08861/2016

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On 27 February 2019	**On 29 August 2019**

Before

UPPER TRIBUNAL JUDGE CANAVAN

Between

MOURAD HENNICHE

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the appellant: Ms F. Shaw, instructed by Kamberley Solicitors
For the respondent: Mr S. Whitwell, Senior Home Office Presenting Officer

DECISION AND REASONS

1. The appellant appealed the respondent's decision dated 10 March 2016 to refuse a human rights claim. First-tier Tribunal Judge Clarke allowed the appeal in a decision dated 11 January 2018. Deputy Upper Tribunal Judge Taylor set aside the decision because it involved the making of an error of law on 19 July 2018. The appeal was listed for a further hearing for the decision to be remade.

2. I am conscious of the delay in promulgating this decision. Unfortunately, it has taken longer than usual to prepare due to the complexity of some of the issues, the nature of the evidence and the pressure of other work.

Background

3. The appellant is an Algerian citizen who entered the UK in July 2000 with leave to enter as a visitor. He remained in the UK after his visa expired in the full knowledge that he did not have permission to do so. He says that he lived with his brother from 2000 to 2008. He now lives with friends, but his brother continues to provide financial support.

4. In 2003 he was diagnosed with coeliac disease. On 21 March 2013 he was served with a notice of liability to removal (IS 151A). On 12 August 2013 the appellant was refused leave to remain without a right of appeal.

5. The appellant made an application for leave to remain on human rights grounds on 27 November 2015. The respondent refused the application on 10 March 2016. The appellant did not meet the requirement of 20 years' long residence under paragraph 276ADE(1)(iii) of the immigration rules. There were no 'very significant obstacles' to his integration in Algeria so he did not meet the requirements of paragraph 276ADE(1)(vi). The respondent considered whether the appellant's medical condition constituted exceptional circumstances that might justify a grant of leave to remain on human rights grounds but concluded that it did not. The evidence indicated that treatment was likely to be available in Algeria.

Legal framework

6. Article 3 of the European Convention on Human rights provides that no one shall be subject to torture, inhuman and degrading treatment. In cases where the sole reason why the person asserts that they will be subjected to such treatment if removed from the UK is a medical or psychiatric condition a person must show a very exceptional case featuring compelling humanitarian circumstances before their removal would breach Article 3: see *N v SSHD* [2005] UKHL 31 and *N v UK* (2008) 47 EHRR 39. The courts have concluded that there is no medical care obligation on signatory states to the European Convention even when removal might significantly shorten a person's life expectancy due to less adequate medical care in their country of origin.

7. The more recent decision of the European Court in *Paposhvili v Belgium* [2017] Imm AR 867 found that the principles were not confined solely to deathbed cases. The 'other very exceptional cases' referred to in *N v UK*: "should be understood to refer to situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being

exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy."

8. In *AM (Zimbabwe) v SSHD* [2018] EWCA Civ 64 and *MM (Malawi) v SSHD* [2018] EWCA Civ 2482 the Court of Appeal observed that if there was some relaxation of the test it was "only to a very modest extent". The decision of the House of Lords in *N v SSHD* was still binding. The Article 3 threshold in medical cases remained high.

9. Article 8 of the European Convention protects the right to 'physical and moral integrity', which can include a person's health: see *Bensaid v UK* (2001) 33 EHRR 10. Unlike Article 3, Article 8 is not an absolute right. In the absence of any additional factors that might engage Article 8 the threshold for showing a breach of Article 8 solely on medical grounds is equally high: see *GS (India) v SSHD* [2015] EWCA Civ 40 and *MM (Zimbabwe) v SSHD* [2012] EWCA Civ 279. The Court of Appeal in *SL (St Lucia) v SSHD* [2018] EWCA Civ 1894 concluded that the decision in *Paposhvili* did not affect this principle.

> "27. … I am entirely unpersuaded that Paposhvili has any impact on the approach to article 8 claims. As I have described, it concerns the threshold of severity for article 3 claims; and, at least to an extent, as accepted in AM (Zimbabwe), it appears to have altered the European test for such threshold. However, there is no reason in logic or practice why that should affect the threshold for, or otherwise the approach to, article 8 claims in which the relevant individual has a medical condition. As I have indicated and as GS (India) emphasises, article 8 claims have a different focus and are based upon entirely different criteria. In particular, article 8 is not article 3 with merely a lower threshold: it does not provide some sort of safety net where a medical case fails to satisfy the article 3 criteria. An absence of medical treatment in the country of return will not in itself engage article 8. The only relevance to article 8 of such an absence will be where that is an additional factor in the balance with other factors which themselves engage article 8 (see (MM (Zimbabwe) at [23] per Sales LJ). Where an individual has a medical condition for which he has the benefit of treatment in this country, but such treatment may not be available in the country to which he may be removed, where (as here) article 3 is not engaged, then the position is as it was before Paposhvili, i.e. the fact that a person is receiving treatment here which is not available in the country of return may be a factor in the proportionality balancing exercise but that factor cannot by itself give rise to a breach of article 8. Indeed, it has been said that, in striking that balance, only the most compelling humanitarian considerations are likely to prevail over legitimate aims of immigration control (see Razgar at [59] per Baroness Hale).
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> 28. Therefore, in my firm view, the approach set out in MM (Zimbabwe) and GS (India) is unaltered by Paposhvili; and is still appropriate. I do not consider the contrary is arguable."

10. Paragraph 276ADE(1)(vi) of the immigration rules is said to reflect the respondent's position as to where a fair balance should be struck for the purpose of assessing a

person's private life under Article 8. At the date of the respondent's decision the requirements were:

> "276ADE (1). The requirements to be met by an applicant for leave to remain on the grounds of private life in the UK are that at the date of application, the applicant:
>
> (i) does not fall for refusal under any of the grounds in Section S-LTR 1.1 to S-LTR 2.2. and S-LTR.3.1. to S-LTR.4.5. in Appendix FM; and
>
> (ii) has made a valid application for leave to remain on the grounds of private life in the UK; and
>
> …
>
> (vi) subject to sub-paragraph (2), is aged 18 years or above, has lived continuously in the UK for less than 20 years (discounting any period of imprisonment) but there would be very significant obstacles to the applicant's integration into the country to which he would have to go

11. In *Kamara v SSHD* [2016] EWCA Civ 813 the Court of Appeal considered the test set out in section 117C(4)(c) of the Nationality, Immigration and Asylum Act 2002 ("NIAA 2002"). Although the assessment related to a somewhat different test, which applies in deportation cases, the wording 'very significant obstacles' to integration forms part of the test and is equally applicable to a proper interpretation of paragraph 276ADE(1)(vi).

> "14. In my view, the concept of a foreign criminal's 'integration' into the country to which it is proposed that he be deported, as set out in section 117C(4)(c) and paragraph 399A, is a broad one. It is not confined to the mere ability to find a job or to sustain life while living in the other country. It is not appropriate to treat the statutory language as subject to some gloss and it will usually be sufficient for a court or tribunal simply to direct itself in the terms that Parliament has chosen to use. The idea of 'integration' calls for a broad evaluative judgment to be made as to whether the individual will be enough of an insider in terms of understanding how life in the society in that other country is carried on and a capacity to participate in it, so as to have a reasonable opportunity to be accepted there, to be able to operate on a day-to-day basis in that society and to build up within a reasonable time a variety of human relationships to give substance to the individual's private or family life."

12. Although both parties referred to the decision in *AS v SSHD* [2018] EWCA Civ 1284, the case does not develop the principles much further. Although a psychological report formed part of the evidence before the Tribunal in that case, it does not appear that the case for arguing that there were 'very significant obstacles' to integration in the context of deportation proceedings was put squarely on medical grounds. Nevertheless, I accept that it is trite law that medical issues are capable of being relevant to an assessment under Article 8.

13. The final case I was referred to was *Parveen v SSHD* [2018] EWCA Civ 932, which was decided in the context of paragraph 276ADE(1)(vi). The court emphasised:

> "9. The task of the Secretary of State, or the Tribunal, in any given case is simply to assess the obstacles to integration relied on, whether characterised as hardship or difficulty or anything else, and to decide whether they regard them as "very significant"."

Decision and reasons

14. The appellant is a 52-year-old man who had lived in the UK for a period of nearly 19 years at the date of the hearing. Save for a few months when he first arrived in the UK the appellant knowingly remained without leave. In evidence at the hearing he said that he did not enter the UK with the intention of receiving medical treatment. I accept that this is likely to be the case because the evidence shows that he was not diagnosed with coeliac disease until 2003. However, it does mean that he did not intend to return home at the end of the visit because he overstayed for some time before the diagnosis. Save for three sessions of private treatment when he arrived in the UK the appellant's treatment has been at the expense of the British taxpayer.

15. The appellant told me that he worked for an oil company for 10 years in Algeria. He worked in the workshop where they made parts for the pipelines and refineries. He said that it was a physical job that required "some effort". He is educated to the equivalent of A level standard.

16. His mother, a brother and two sisters still live in Algeria. His mother lives in a one bedroom flat in Algiers. The rent is paid by his late father's pension. His mother spends some time with family members. During that time the flat is empty. The appellant said that his brother in Algeria works but the nature of his employment was not drawn out in evidence. The appellant suggested that he was not rich and had responsibilities towards his own family. He said that his sisters are married and confirmed that their husbands worked for state companies. One of them worked for the same oil company. His brother in law was the one who helped him to find work there. The appellant said that it would not be culturally acceptable for him to live with their families.

17. Although it is understandable that connections with old friends in Algeria might have become distant or may have been severed during the lengthy period he has lived in the UK, the appellant's sister was able to contact a friend of his in Algeria when she was preparing evidence for this case. It is possible that the appellant may be able to renew other connections in Algeria.

18. In the UK, the appellant lived with and was supported by his brother for many years. When his brother married the appellant moved out. Friends accommodate him. His brother works as a security guard and still provides financial support. His brother claimed that it would be difficult to provide financial support if the appellant returned to Algeria because he did not earn very much and had to support his family. The level of financial support that he currently provides was not clarified in evidence at the hearing. However, it is reasonable to infer that he could

provide the same level of financial support he currently does, which at the very least includes support to buy some food and clothing.

19. The appellant admitted to having carried out casual work during his time in the UK. He said that he did not have any official jobs but helped people out when they asked. Sometimes he might help to make deliveries or cover when someone is on holiday. He sometimes covered for a friend of his who delivers goods to restaurants.

20. The appellant is not married and does not have children. It is reasonable to infer that he has friendship connections and has developed some form of private life in the UK over the years, but there is little evidence to suggest any significant connections to the UK.

21. The appellant's case relies primarily on his medical condition. The bundle before the First-tier Tribunal contained a number of pieces of correspondence and copies of various medical records showing that he has received regular monitoring and treatment of this condition from around 2009 onwards. I will concentrate on the most recent evidence.

22. A letter from his GP dated 09 July 2018 says that he was diagnosed with Type 2 Refractory Coeliac Disease in 2003, ulcerative colitis and associated malabsorbtion. He is under the care of Professor Ciclitira at Guys and St Thomas' Hospital and had been referred to a Consultant Hematologist for investigation into monocytosis (increase in white blood cells).

23. A letter from Dr Joel Mawdsley, a consultant gastroenterologist, to the appellant's GP dated 21 June 2018 noted that his coeliac disease was up and down. He was suffering from abdominal pain, cramping and diarrhoea and had lost 8 kg over the previous 2-3 months. Dr Mawdsley expressed some concern over his weight loss. He said that he would arrange an urgent CT scan and had checked his blood tests. Dr Mawdsley noted that there would be a "virtual review" in four weeks. At the hearing the appellant confirmed that no particular concerns were disclosed by the further tests he had in 2018.

24. In a letter dated 27 November 2018, prepared in response to questions from the appellant's solicitor, Professor Ciclitira said:

> "He is known to have type 2 refractory coeliac disease. He underwent a resection of a fibrotic stricture of the small intestine in 2011, the histology of which confirmed a diagnosis of type 2 refractive coeliac disease. His condition untreated has a greater than 50% mortality, and he was treated at the time, and since then with Methotrexate once weekly, Mycophenolate 500mg twice daily, Prednisolone 5mg daily and other vitamin supplementation. Other investigations over a period of time reveal that he continues to suffer from this condition – that is type 2 refractory coeliac disease, which is an expansion of a clone of T-cells that, in my opinion, if untreated, would result in him

developing enteropathy associated T-cell lymphoma (EATL) complicating his type 2 refractory coeliac disease.

If he was required to leave the UK it is inevitable that this condition would be exacerbated. There is a high – i.e: greater than 50% chance – of resulting mortality. I do not believe such care would be available in his country of origin – that is, Algeria. I therefore strongly appeal to the Tribunal that this gentleman be allowed to remain in the UK so that he can continue his medication and management of what could otherwise be a fatal condition."

25. The appellant also produced a report from Dr Robin Knill-Jones dated 26 March 2019. Dr Knill-Jones is not one of the appellant's treating clinicians. According to his *curriculum vitae* he completed 12 years' accreditation in General Medicine (Gastroenterology) and Public Health (Epidemiology). He was licensed to practice until September 2016, but the summary of his clinical appointments indicates that his period of clinical practice was from 1964 to 1979. From 1979 to 2005 he was a Senior Lecturer and an Honorary Consultant in Public Health at Glasgow. From 2005 until the present he has been an Honorary Senior Research Fellow at Glasgow. He outlines appointments as a medically qualified member of various panels and tribunals. Most of Dr Knill-Jones' experience in recent years appears to have been academic. The extent of any more recent practical experience in gastroenterology, if any, is unclear. Dr Knill-Jones prepared his report solely by reference to the appellant's medical notes and correspondence.

26. Dr Knill-Jones outlined the appellant's medical history. The appellant was diagnosed with coeliac disease in 2003 and was advised to follow a gluten free diet. He was later treated with Azathioprine and steroids. By September 2010 the dose of Azathioprine was doubled to 25mg a week. The appellant had two episodes of hypocalcaemia as a result of poor intestinal calcium absorption for which he is receiving treatment. Intermittent abdominal symptoms led to an episode of small bowel obstruction, which required surgery in April 2011. The notes suggested that he visited his GP for regular blood tests around once a month in order to monitor the use of Azathioprine. The notes indicated that he visited the GP around 15 times in 2018 and attended hospital outpatient appointment around eight times in the same year. His weight remained fairly constant. His serum albumen levels have tended to be low, which Dr Knill-Jones says, without any further explanation, is a poor prognostic sign.

27. Dr Knill-Jones observed that the notes mentioned the appellant working at a restaurant called Momo in April 2013, January 2014 and December 2017. He commented "there was no suggestion that this was intermittent." Dr Knill-Jones also noted a handwritten letter amongst the correspondence from the appellant to his GP practice requesting "…the last three years medical reports as my Doctor in Algeria need to know more about my health to carry on providing me with medicines if… any needs while I'm on holiday". Dr Knill-Jones said that this suggested that the appellant does know doctors in Algeria.

28. Dr Knill-Jones' report goes on to make comments about the availability of healthcare in Algeria. No explanation is provided as to the source of the information. He stated that there is an active Gastroenterological Association in Algeria and a health service was established in 1975 to cover the whole population. He said coeliac disease is relatively common across North Africa and Algeria "probably has one of the highest prevalence in the world, about 1.5% of the population, compared to about 1% in the UK". He inferred that it was likely that there is plenty of local clinical experience of the condition in Algeria, but this did not mean that all the necessary treatment is available.

29. Dr Knill-Jones observed that the current aim of the appellant's treatment would be to reduce the possible development of a T-cell lymphoma, which is a known risk of type 2 coeliac disease. Type 2 is a rare form of coeliac disease. Once diagnosed there is a 60-80% incidence of lymphoma within five years. Given that the appellant was diagnosed with type 2 nine years ago he has done relatively well. Once lymphoma develops treatment is not very effective with a 10-20% incidence of survival after five years. Although he is now in a small group of survivors beyond five years since diagnosis, the prognosis remains guarded. His current treatment needs to be continued.

30. Dr Knill-Jones was uncertain whether adequate treatment is available in Algeria. Mycophenolate (Mofetil) is available in the UK for about £100 annually but might be more expensive and less easily available in Algeria. Stopping the medication might have a deleterious effect on his prognosis. In Dr Knill-Jones' view the other medication is standard and is likely to be available in Algeria. Regular small bowel endoscopy with biopsy is an important component of the management of the appellant's condition. He did not know whether this was available in Algeria.

31. The evidence shows that the appellant has received ongoing treatment for type 2 refractory coeliac disease over a number of years. The condition is being managed through medication and regular monitoring. Neither Professor Ciclitira nor Dr Knill-Jones purported to have any specific knowledge of the availability of treatment in Algeria. Professor Ciclitira made an unsupported assertion that it was his belief that appropriate care would not be available in Algeria. Dr Knill-Jones was able to provide some comment about the likely availability of standard medications but made clear that he was unsure whether Mycophenylate was available in Algeria or endoscopy services.

32. In the absence of any specific or reliable knowledge of Professor Ciclitira or Dr Knill-Jones relating to the availability of treatment in Algeria, the burden falls on the appellant to produce evidence to show what treatment, if any, is available.

33. A letter from the appellant's sister dated 15 July 2018 says that it would be difficult to manage his disease in Algeria. Firstly, it is not listed among the chronic diseases giving entitlement to benefits. Secondly, the hospitals in Algeria are overloaded and lack means and equipment. Thirdly, the expense of care in private clinics is beyond

the means of most people on a limited income. She says that there is less food available appropriate for people on gluten free diets. What there is, is more expensive. She said that her family would not be able to afford to take care of the appellant because they have a limited income. Although she is well educated and is completing a PHD in Demographic Sociology relating to "Health Culture", she is unable to find work due to the lack of job opportunities caused by the economic crisis in the country.

34. The bundle includes a document dated 02 July 2016 entitled "List of 26 Diseases Taken in Charge". Little other information is provided about the document. However, it indicates that it is a list of diseases that give entitlement to benefits. I find that it is reasonable to infer that this is the list of diseases mentioned by the appellant's sister for which funding for healthcare appears to be available although the source is unclear. The list includes "cancerous diseases" at (3), "serious and lasting complications of gastrectomies and ulcerative disease" at (22), and "ulcerative colitis" at (24). Although I note that the last two are different gastrointestinal diseases, it indicates that some treatment is likely to be available for gastrointestinal problems in Algeria.

35. Other background new articles talk about high levels of unemployment in Algeria and the scarcity of some medications. Two articles that appear to be from online sources in Algeria discuss the difficulties faced by people with coeliac disease. The first is an article from News Today dated 10 November 2015, which discusses the difficulties coeliac patients have in accessing gluten free alternatives for their diet. Such foods are limited. Alternatives such as rice are imported and therefore cost more. The second article is from a website called El-massa.com and appears to be undated. The article covers similar ground to the first in relation to the price and availability of gluten free foods in Algeria. The article discusses the difficulty in finding good quality gluten free foods such as pastries and pasta.

36. Another piece of evidence relating to the situation in Algeria is a letter from Dr Henniche Abdellah dated 30 November 2018. The original copy of the letter is not provided, only an unsigned translation. No explanation is provided as to who Dr Abdellah is or his expertise to comment on the appellant's medical condition. It is unclear whether he has treated the appellant in the past. The translation of a seal that is said to be on the original document indicates that Dr Abdellah is a rheumatologist and does not appear to be a specialist gastroenterologist. The translation states:

> "Patient Mourad Henniche suffers from celiac disease (chronic enthetopathy) due to gluten intolerance diagnosed clinically, biologically and conformed by intestinal biopsies in 2003.
>
> Mister Mourad Henniche suffers from all the complications of the disease: an anemia by deficiency in Folate and B12, an osteopenia by calcium deficiency due to malabsorption. Given his condition, the patient requires care and rigorous follow up, a strict regime, drug treatments, biological assessments and

annual fibroscopy, according to the evolution of the disease. This makes the care of such a disease and its complications very expensive and difficult, due to the incapacity of the patient to take care of himself financially in Algeria. (sic)"

37. The last piece of evidence that might be relevant is a letter in English dated 04 April 2013 purporting to be from Professor Nabil Debzi of the Mustapha Hospital in Algiers. The letter states:

> "I'm Professor Nabil DEBZI Hepatogastroenterologist at Mustapha Hospital Algiers and have been asked to provide an assessment as to whether treatment for Mr Mourad HENNICHE is available in Algeria.
>
> Mr. HENNICHE suffers from coeliac disease and severe ulcerative jejunitis and I regret that we do not have the facilities to treat the bowel related problems of Mr HENNICHE in Algeria. I confirm that we do not have the expertise to deal with this condition nor the aftercare required."

38. I find that little weight can be placed on this letter as evidence to show that treatment is not available in Algeria. The letter is unsigned. It is not on headed paper. It is unclear what information Professor Debzi was given in order to provide this opinion. Even then, the letter is vague in nature and does not explain how or why the appellant's condition is so complicated that the hospital would be unable to provide the necessary treatment. Given that the appellant's care consists of monitoring through blood tests and endoscopy it is not plausible that such basic care is not available in a hospital gastroenterology department. Professor Debzi does not say that such care is not available, nor does he go into detail about the availability or otherwise of the necessary medication. In short, the letter is too vague to be given any meaningful weight.

39. The evidence shows that the appellant suffers from a chronic long-term disease that is managed through diet, monitoring, medication, and on one occasion, through surgical intervention. The appellant is in a category of people whose coeliac disease places him at higher risk of developing T-cell lymphoma, which would be difficult to treat. If his condition is untreated there is more than 50% risk of death. However, Professor Ciclitira does not say how rapidly the appellant's health is likely to deteriorate if his condition is untreated.

40. The first issue is whether the appellant's condition would be left untreated if returned to Algeria. There is no reliable evidence to suggest that treatment is not in fact available in Algeria. Nothing in the evidence given by the appellant's sister nor by Dr Abdellah or Professor Debzi suggests that the required treatment is not available. It is reasonable to infer that basic monitoring techniques such as blood tests are available. It is also reasonable to infer from the fact that treatment is available for other gastroenterological conditions that other basic monitoring procedures such as endoscopy services are likely to be available.

41. Dr Knill-Roberts considered most of the medication that the appellant is receiving to be of a basic nature that is likely to be available in Algeria. The only concern that he had was the possible availability of Mycophenolate, which the appellant takes

on a daily basis. There is no evidence to show that Mycophenolate is not available in Algeria. The only evidence given by Dr Abdellah and the appellant's sister are general assertions that medications and associated treatment are likely to come at some cost. Even if Mycophenolate is not available, the evidence of Dr Knill-Roberts indicates that a yearly supply is eminently affordable if bought in the UK. It might be possible for his brother to enquire about the possibility of buying the relevant medication here if necessary. In short, the appellant has failed to show that the necessary treatment is not available in Algeria.

42. While I have no doubt that the appellant will have times where his condition flares up and he is more unwell than others, the evidence shows that, despite his condition, the appellant has been well enough to work in the UK on a seemingly regular basis, albeit without permission. It also shows that he was able to find stable long-term work through his brother in law in Algeria in the past. I accept that it may not be the cultural norm for an unmarried man to live with his sisters' families in Algeria. However, the appellant is not without family support. If he were to return to Algeria his brother or his mother may be able to provide him with accommodation. He is currently reliant on friends for such support and I can see no reason why he couldn't rely on family or friends in Algeria in a similar way. I accept that his brother in the UK has responsibilities for his own family, but his evidence is that he still able to provide some financial support to the appellant. I can see no reason why he could not contribute similar amounts to support his brother if he returned to Algeria.

43. The fact that specialist gluten free products such as pastry and pasta are less readily available in Algeria is in my view immaterial. While they are widely available in the UK such foods are not an essential part of a gluten free diet, which could be followed by eating fresh local produce. The evidence relating to this point is too vague to place any weight on it.

44. The fact that the appellant can work and has family support in Algeria indicates that he would not be returning to a situation where he would be destitute or unable to afford any treatment for his condition. The evidence relating to the availability of treatment in Algeria is vague. So too is the medical evidence as to how rapidly the appellant's condition might decline if he were unable to afford to access treatment that is likely to be available in Algeria.

45. I turn to consider these facts with reference to the relevant legal framework. The evidence falls far short of showing the kind of very exceptional circumstances of a compelling humanitarian nature of the kind that would engage the operation of Article 3 of the European Convention. It is understandable that the appellant is concerned that he might not be able to afford the same level of treatment in Algeria, but the courts have repeatedly made clear that a signatory state to the European Convention does not have an obligation to treat non-nationals. There is insufficient evidence to show that the appellant would not receive treatment or to show that the absence of treatment would lead to a rapid decline in his condition of the

compelling nature needed to engage Article 3. The evidence does not show that the appellant is a particularly vulnerable person who could not look after himself, he continues to have familial connections in Algeria and would not be left wholly unsupported.

46. The case law shows that absent a combination of other circumstances that might be relevant to an assessment under Article 8 of the European Convention the threshold is equally high. In this case the only other element that might be relevant to the assessment under Article 8 is the appellant's length of residence in the UK. Undoubtedly, 19 years' residence is a long time. However, section 117B(4) NIAA 2002 states that little weight should be placed on a private life formed at a time when the person has been in the UK unlawfully. Although it is reasonable to assume that he has established some form of private life here in that time, there is little evidence to suggest that he has established particularly strong connections. The appellant's length of residence is not a compelling factor, even taken with his medical condition, which would elevate the circumstances to the threshold that might be required to show a disproportionate breach of Article 8.

47. Indeed, Ms Shaw did not argue that the appellant's circumstances were sufficiently compelling to meet the elevated threshold required in medical cases under Articles 3 and 8. The case was argued solely in relation to paragraph 276ADE(1)(vi).

48. The first thing to note about paragraph 276ADE(1) is that the provision is intended to reflect the respondent's position as to where a fair balance is struck in relation to various situations that might engage a person's right to respect for private life. The provision sets out specific situations in which the respondent accepts that, if the person meets the requirement, it would be disproportionate to expect him to leave the UK. The provision does not provide a holistic assessment of the circumstances in the same way that a full Article 8 balancing exercise would do.

49. The second point to note is that, although Article 8 can include consideration of a person's health condition, the wording of paragraph 276ADE(1)(vi) is clearly focused on 'integration' in the person's country of origin. The provision is more likely to apply to those who have no meaningful connections or knowledge of life in their country of origin, mostly likely because they were brought to the UK at a young age. On the face of it the provision is not specifically designed to include consideration of health concerns for a person who might otherwise have continuing linguistic, cultural and familial connections with their country of origin. Nevertheless, it is not difficult to imagine that a small minority of medical cases might engage the considerations outlined in *Kamara*. Those circumstances would have to be unusual and compelling in order to show that a person would not understand of how life in the society is carried on or would not have capacity to participate in it and to operate on a day-to-day basis. One example might be a person who suffers from severe mental illness such that they do not have capacity or insight to seek treatment and did not have familial or other support in their

country of origin, who would as a result, suffer the kind of inhuman and degrading treatment envisaged to reach the Article 3 threshold.

50. The third point of note is that, even if paragraph 276ADE(1)(vi) is capable of including an assessment of a person's medical condition, and it forms the main reason why it is said that person would face 'very significant obstacles' to integration, the threshold for that test must be equally as stringent as in other medical cases. It cannot be right that paragraph 276ADE(1)(vi), as a reflection of the respondent's position relating to Article 8, provides a less stringent test than the case law dictates in relation to a more wide ranging assessment of medical cases under Article 8. In a case where it is argued that there are 'very significant obstacles' to a person's integration in their country of origin based on a medical condition the evidence must disclose equally compelling humanitarian considerations in order to show that removal would amount to a disproportionate breach of Article 8.

51. In this case, the appellant was born and brought up in Algeria. He was educated there and worked for 10 years before coming to the UK. He is familiar with Algerian culture. He still has contact with family members there. Within the general meaning of the term 'integration' it is not arguable that the appellant would not be familiar with how day-to-day life in Algeria works or would not have social and familial connections upon which to build a meaningful private life there.

52. The appellant's medical condition is not of the kind where he would not have the capacity or understanding to seek treatment. He has failed to produce sufficient evidence to show that treatment is unavailable in Algeria. He might have to pay for treatment. He might find it difficult to raise the funds for some of the treatment, but the appellant is well enough to find work and is likely to have the benefit of the combined financial support of his family members. He might not be able to afford to have as many tests and such regular monitoring; it might be that some medication must be prioritised if he cannot afford the full range of treatment. It is understandable that the appellant is concerned that he might not be able to afford the same level of care as in the UK, which might in turn lead to an increased risk in developing T-cell lymphoma. However, the UK is under no obligation to continue to treat the appellant, who is not a British national and does not otherwise meet the requirements for leave to remain in the UK, unless the circumstances he is likely to face on return to Algeria disclose the kind of very exceptional humanitarian considerations required to show a breach of Articles 3 or 8 of the European Convention.

53. Although I accept that the 'very significant obstacles' to integration test contained in paragraph 276ADE(1)(vi) is capable of being engaged in a medical case, given the focus on 'integration' as the test, it seems likely that it would only be in an usual and compelling cases that a case might succeed given the high threshold required in medical cases.

54. Unfortunately, this is not one of those cases. Those representing the appellant, quite rightly, did not argue that the evidence met the high threshold required under Articles 3 and 8. Paragraph 276ADE(1)(vi) is still intended to reflect Article 8. Even then, it is not arguable that the difficulties that the appellant might face in obtaining treatment in Algeria comes anywhere near showing that he would face very significant obstacles to integration in Algeria given his other connections there.

55. I conclude that the removal of the appellant in consequence of the decision would not be unlawful under section 6 of the Human Rights Act 1998.

DECISION

The appeal brought on human rights grounds is DISMISSED

Signed  Date 27 August 2019
Upper Tribunal Judge Canavan