



Upper Tribunal  
(Immigration and Asylum Chamber)

Appeal Number: IA/19553/2015

**THE IMMIGRATION ACTS**

Decided on the papers  
On Monday 4 September 2017  
[Following oral hearing in Liverpool on 5  
June 2017]

Decision & Reasons Promulgated  
On Monday 9 October 2017

Before

UPPER TRIBUNAL JUDGE SMITH

Between

MR AMMAR HUSSEIN

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

**Representation:**

For the Appellant: Mr Schwenk, Counsel instructed by Arshed and Co solicitors  
For the Respondent: Mr Harrison, Senior Home Office Presenting Officer

**DECISION AND REASONS**

**Background**

1. The Appellant is a national of Pakistan who appeals against the Respondent's decision dated 6 May 2015 refusing him further leave to remain under Article 8 ECHR on the basis of his medical condition and the private life he has formed since

arriving in the UK last in 2004. The refusal of leave to remain followed the grant of a period of discretionary leave in 2012. His appeal against the Respondent's decision was dismissed by First-tier Tribunal Judge G D Tobin in a decision promulgated on 9 May 2016 on the basis that there were "no insurmountable obstacles" to the Appellant returning to Pakistan to continue his medical treatment and there was no reason to allow the appeal outside the Rules.

2. This appeal came before me first on 17 January 2017 when I found an error of law in Judge Tobin's decision, set that aside and gave directions for a further hearing to include consideration of updated medical evidence and legal submissions relating, in particular, to the import and application of the European Court's decision in Paposhvili v Belgium (Application No 41738/10). My earlier decision is appended to this decision for ease of reference.
3. The main focus of the appeal is the Appellant's medical condition (although I have also received evidence as to his private life formed in the UK). The Appellant has undergone a kidney transplant in the UK. He continues to receive treatment and medication to maintain his health. I set out below the most recent evidence as to his condition and the evidence received on both sides as to the availability of treatment in Pakistan.
4. The resumed hearing took place on 5 June 2017. The Respondent failed to meet the deadline for her skeleton argument and further evidence. On that basis, Counsel for the Appellant objected to the admission of the further evidence. I declined to shut out that evidence as I considered that I would be assisted by as much evidence as possible as to the treatment available in Pakistan (particularly when the Appellant's position is that the availability of treatment in his home country is of greater relevance following the judgment in Paposhvili). I therefore indicated that I would receive submissions on the legal position and such evidence as existed at the date of the hearing but would permit the Appellant to adduce further evidence about the treatment available in Pakistan, following which I would re-make the decision on the papers, taking into account any additional evidence and the evidence and submissions considered at the hearing on 5 June 2017.
5. I received further evidence in writing from the Appellant's solicitors under cover of a letter dated 3 July 2017. I refer to that so far as relevant below.

### **Relevant Case Law**

6. Although the Appellant's application refused by the Respondent's decision under appeal was initially based on Article 8 ECHR, the Appellant now relies also on Article 3 ECHR. He contends that, as a consequence of his medical condition and the lack of treatment available to him in Pakistan, return will lead to him suffering to the extent that his condition will involve inhuman and degrading treatment. He relies in particular on Paposhvili in support of a submission that the level of suffering required to breach Article 3 ECHR is lowered from the cases which have in the past

succeeded (see in particular D v United Kingdom [1997] ECHR 30240/96 and the distinguishing of that case in N v United Kingdom [2008] EHRR 39).

7. Paposhvili v Belgium (Application 41738/10) - Grand Chamber Judgment: 13 December 2016

This case concerned the removal from Belgium to Georgia of a person suffering from leukaemia, tuberculosis and hepatitis C. The appellant had also suffered a stroke and had his fingers amputated. His conditions had been stabilised by treatment in Belgium by the time of the removal decision but it is right to note as did the Grand Chamber at [195] that without the treatment which the appellant was receiving in Belgium, his life expectancy was less than six months. It is also worthy of note that the treatment which the appellant was receiving in Belgium for his leukaemia in particular was the only hope which the appellant had of a cure.

8. The European Court of Human Rights held at first instance that, following the case law in D v UK and N v UK, the case should be dismissed. The Grand Chamber overturned that decision. Although the Grand Chamber cited the previous case law and did not disapprove it, it went on to depart from those cases. The reasoning for its decision is to be found in the following paragraphs (cited so far as relevant):-

“[181] The Court concludes from this recapitulation of the case-law that the application of Article 3 of the Convention only in cases where the person facing expulsion is close to death, which has been its practice since the judgment in *N v the United Kingdom*, has deprived aliens who are seriously ill, but whose condition is less critical, of the benefit of that provision. As a corollary to this, the case-law subsequent to *N v the United Kingdom* has not provided more detailed guidance regarding the “very exceptional cases” referred to in *N v the United Kingdom*, other than the case contemplated in *D v the United Kingdom*.

[182] In the light of the foregoing, and reiterating that it is essential that the Convention is interpreted and applied in a manner which renders its rights practical and effective and not theoretical and illusory... the Court is of the view that the approach adopted hitherto should be clarified.

[183] The Court considers that the “other very exceptional cases” within the meaning of the judgment in *N v the United Kingdom* .. which may raise an issue under Article 3 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. The Court points out that these situations correspond to a high threshold for the application of Article 3 of the Convention in cases concerning the removal of aliens suffering from serious illness.

[184] ...the primary responsibility for implementing and enforcing the guaranteed rights and freedoms is laid on the national authorities, who are thus required to examine the applicants’ fears and to assess the risk they would face if removed to the receiving country, from the standpoint of Article 3....

[185]...in cases of this kind, the authorities’ obligation under Article 3 to protect the integrity of the persons concerned is fulfilled primarily through appropriate procedures allowing such examination to be carried out...

[186] In the context of these procedures, it is for the applicants to adduce evidence capable of demonstrating that there are substantial grounds for believing that, if the measure complained of were to be implemented, they would be exposed to a real risk of being subjected to treatment contrary to Article 3...a certain degree of speculation is inherent in the preventive purpose of Article 3 and that it is not a matter of requiring the persons concerned to provide clear proof of their claim that they would be exposed to proscribed treatment....

[187] Where such evidence is adduced, it is for the authorities of the returning State, in the context of the domestic procedures, to dispel any doubts raised by it... The risk alleged must be subjected to close scrutiny...in the course of which the authorities in the returning State must consider the foreseeable consequences of removal for the individual concerned in the receiving State, in the light of the general situation there and the individual's personal circumstances...The assessment of the risk ...must therefore take into consideration general sources such as reports of the World Health Organisation or of reputable non-governmental organisations and the medical certificates concerning the person in question.

[188]...what is in issue here is the negative obligation not to expose persons to a risk of ill-treatment proscribed by Article 3. It follows that the impact of removal on the person concerned must be assessed by comparing his or her state of health prior to removal and how it would evolve after transfer to the receiving State.

[189] ....the authorities in the returning State must verify on a case-by-case basis whether the care generally available in the receiving State is sufficient and appropriate in practice for the treatment of the applicant's illness so as to prevent him or her being exposed to treatment contrary to Article 3...The benchmark is not the level of care existing in the returning State; it is not a question of ascertaining whether the care in the receiving State would be equivalent or inferior to that provided by the health-care system in the returning State. Nor is it possible to derive from Article 3 a right to receive specific treatment in the receiving State which is not available to the rest of the population.

[190] The authorities must also consider the extent to which the individual in question will actually have access to this care and these facilities in the receiving State. The Court ...has previously questioned the accessibility of care...and referred to the need to consider the cost of medication and treatment, the existence of a social and family network, and the distance to be travelled in order to have access to the required care...

[191] Where, after the relevant information has been examined, serious doubts persist regarding the impact of removal on the persons concerned – on account of the general situation in the receiving country and/or their individual situation – the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the persons concerned so that they do not find themselves in a situation contrary to Article 3..."

8. The main distinctions to be drawn based on this reasoning are two-fold. First, the Grand Chamber recognises that its decision marks a departure from what were previously considered to be exceptional cases (sometimes referred to as "deathbed" cases) on the basis of the extremely high threshold for medical impact which was required to be shown. Second, assessment of whether a "real risk" of Article 3 treatment will involve consideration of evidence as to availability of treatment to reduce the risk below that threshold which imports considerations not merely

whether treatment is offered in the country of return but whether such treatment is affordable and likely therefore to be able to be accessed by a claimant. It is for a claimant to provide evidence but in some cases, it may be necessary for the returning State to investigate for itself what treatment is available and accessible and in some cases, it may be necessary for the returning State to seek assurances from the destination State.

9. The Appellant accepts however that the bench-mark for what care is “sufficient and appropriate” is not that which exists in the returning State and that the test does not involve drawing comparisons to disparities between the level of treatment in that State and the home country. The real question (as identified at [192] of Paposhvili) is whether removal will expose an applicant to a “real risk” of Article 3 ill-treatment. The threshold for a real risk under Article 3 is of course a high one.
  
10. The Respondent relies on domestic case-law, in particular GS (India) v Secretary of State for the Home Department [2015] EWCA Civ 40 which is of particular application in this case as it dealt with medical issues involving kidney failure. She draws my attention in particular to the following passage:-
 

“[66] These citations demonstrate that in the view of the House of Lords the D exception is confined to deathbed cases. Miss Lieven submitted that the focus of their Lordships’ reasoning (at least that of Lord Nicholls) was upon those with AIDS, a condition much more often suffered than ESKD; so that the strictures in N should not be taken to apply to the latter class of case. But that would be merely adventitious, and therefore unprincipled; and I can find nothing to support it in their Lordships’ speeches.

[67] The result is all of a piece with the repeated statements in the Strasbourg court that ‘[a]liens who are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance and services provided by the expelling State’ (N v UK paragraph 42; cf paragraph 44, and paragraph 54 in D v UK)”
  
11. In any event, the Respondent submits that, on the evidence, the Appellant’s case does not reach the threshold envisaged in Paposhvili. The Respondent relies also on the passage at [183] set out above although obviously to opposite effect. She points out that the threshold is one which is still to be considered to be a very high one. She points out that, in that case, the applicant’s life expectancy was low (and in fact the applicant passed away during the course of the litigation). As such, she says that this would fall within the class of an “exceptional case” in any event. She also points out that the Belgian authorities in that case, had made no attempt to identify what treatment would be available to the applicant on return. Conversely in this case the Respondent has considered the treatment available and in both a previous appeal and before the First-tier Tribunal in this appeal had produced background evidence as to the availability of appropriate medication. She also points out that the Appellant here is effectively seeking to run an argument based on disparity of treatment, which argument was expressly disapproved in Paposhvili (see citation at [189] above).

12. The Respondent also submits that in light of binding domestic case-law, it is not open to me to follow Paposhvili. The Appellant also accepts that Paposhvili involves a departure from, or at the very least an extension of, previous jurisprudence of the ECtHR on which domestic case-law relies. It is accepted therefore that to apply Paposhvili, the domestic Courts will need to revisit the domestic case-law.
13. The Appellant also says that, even if his case does not reach the threshold for engagement of Article 3 ECHR, he is nonetheless entitled to succeed on the basis that there are very significant obstacles to his return (so that paragraph 276ADE(1)(vi) is met) or that, coupled with the private life which he has formed in the UK, his medical condition is sufficient to entitle him to succeed outside the Rules on the basis that respect for his private life outweighs the public interest (although I did not understand the latter submission to be put forward with any great enthusiasm and it does not find mention in the Appellant's skeleton argument).
14. I begin by dealing with the issue whether I am able to take into account Paposhvili, or whether I am bound to disregard it insofar as it is inconsistent with domestic case-law (as the Appellant accepts it is at least to some extent).
15. Section 2 of the Human Rights Act 1998 requires domestic courts to "take into account" decisions of the ECtHR. Our courts are not bound to follow them. As was said by Lord Neuberger in Manchester City Council v Pinnock [2011] UKSC 6, however:
 

"[48]... Where, however, there is a clear and constant line of decisions whose effect is not inconsistent with some fundamental substantive or procedural aspect of our law, and whose reasoning does not appear to overlook or misunderstand some argument or point of principle, we consider that it would be wrong for this Court not to follow that line."
16. The issue which then arises is the extent to which Paposhvili departs from the line of cases dealing with the engagement of Article 3 in medical cases. At [79] of Paposhvili, the Grand Chamber itself recognises that it has for some time declared as inadmissible a number of applications relying on Article 3 in the medical context in reliance on the Grand Chamber's case law established in N. The Grand Chamber in that case had expressly confined Article 3 to "very exceptional cases". The Grand Chamber in Paposhvili did however recognise at [181] of its judgment that its previous case law since N had been such as to "deprive[d] aliens who are seriously ill, but whose condition is less critical, of the benefit of that provision". On the other hand, the passage which I have cited above at [183] of the judgment continues to recognise the very high threshold which continues to apply and the Respondent points out in her skeleton argument that, on the facts of Paposhvili, that could itself have been considered to be what the Strasbourg court had previously described as a "very exceptional case". To treat it as such may not in fact conflict markedly with the approach set out by the Court of Appeal in GS. I draw attention in particular to [42] to [45] of the European Court's judgment in N as cited at [49] in that case as follows:

[42] In summary, the Court observes that since *D v the United Kingdom* it has consistently applied the following principles. Aliens who are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance and services provided by the expelling State. The fact that the applicant's circumstances including his life expectancy, would be significantly reduced if he were to be removed from the Contracting State is not sufficient in itself to give rise to breach of Article 3. The decision to remove an alien who is suffering from a serious mental or physical illness to a country where the facilities for the treatment of that illness are inferior to those available in the Contracting State may raise an issue under Article 3, but only in a very exceptional case, where the humanitarian grounds against the removal are compelling. In the *D* case the very exceptional circumstances were that the applicant was critically ill and appeared to be close to death, could not be guaranteed any nursing or medical care in his country of origin and had no family there willing or able to care for him or provide him with even a basic level of food, shelter or social support.

[43] The Court does not exclude that there may be other very exceptional cases where the humanitarian considerations are equally compelling. However, it considers that it should maintain the high threshold set in *D v the United Kingdom* and applied in its subsequent case-law, which it regards as correct in principle, given that in such cases the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-State bodies, but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country.

[44] Although many of the rights it contains have implications of a social or economic nature, the Convention is essentially directed at the protection of civil and political rights... While it is necessary, given the fundamental importance of Article 3 in the Convention system, for the Court to retain a degree of flexibility to prevent expulsion in very exceptional cases, Article 3 does not place an obligation on the Contracting State to alleviate such disparities through the provision of free and unlimited health care to all aliens without a right to stay within its jurisdiction. A finding to the contrary would place too great a burden on the Contracting States.

[45] Finally, the Court observes that, although the present application, in common with most of those referred to above, is concerned with the expulsion of a person with HIV and AIDS-related condition, the same principles must apply in relation to the expulsion of any person afflicted with any serious, naturally occurring physical or mental illness which may cause suffering, pain and reduced life expectancy and require specialised medical treatment which may not be so readily available in the applicant's country of origin or which may be available only at substantial cost."

17. Based on that passage, Laws LJ in GS declined to expand the Court's reasoning in D for reasons which he explains at [65] of the judgment thus (again by reference to a citations from N - this time the House of Lord's judgment):-

"[36] What was it then that made the case exceptional? It is to be found, I think, in the references to *D*'s 'present medical condition' (para 50) and to that fact that he was terminally ill (paras 51: the advanced stages of a terminal and incurable illness'; para 52: 'a terminally ill man'; para 53: 'the critical stage now reached in the applicant's fatal illness'; Judge Pettiti: 'the final stages of an incurable illness'). It

was the fact that he was already terminally ill while still present in the territory of the expelling state that made his case exceptional.”

He then refers to what is said by Lady Hale in N at [69] as:

“In my view, therefore, the test, in this sort of case, is whether the applicant’s illness has reached such a critical stage (ie he is dying) that it would be inhuman treatment to deprive him of the care which he is currently receiving and send him home to an early death unless there is care available there to enable him to meet that fate with dignity (*per* Lady Hale)”

On the basis of what is said in N, Laws LJ concludes at [66] that “these citations demonstrate that in the view of the House of Lords the D exception is confined to deathbed cases”.

18. On the one hand, therefore, Paposhvili is simply expanding the categories of what constitute a “very exceptional” case. It is not, for example, as the Respondent points out, departing from the principle that the test is not about disparity of treatment between returning and receiving State. It might in that light be seen only as a reflection of further circumstances which are capable of showing a “real risk” of ill treatment on return. On the other, though, there is no doubt that the domestic courts have not understood the previous case-law to be other than that Article 3 in this context is to be very narrowly confined and on the basis of past cases, to include only “death-bed” cases. That though is based squarely on an analysis of the case-law of the European Courts. The domestic courts considered it appropriate to follow that case-law. That case-law has now moved on by reason of Paposhvili. I do not understand what was said by the Supreme Court in Pinnock to preclude me from taking into account the expansion of the potential categories of medical cases which might prevent removal simply because the Supreme Court has previously decided cases based on what the Grand Chamber has said in previous judgments and where the higher courts have not yet had the opportunity to consider this expansion. That is, for reasons I give below, the main impact of Paposhvili on the instant case.
19. In case I am wrong about that, though, I have, when assessing the Article 3 claim considered it both on the basis of the previous domestic authorities and based on what is said in Paposhvili.

## The Evidence

### Medical Evidence

20. The Appellant had a diagnosis of IGA Nephropathy resulting in end stage renal failure. He received dialysis treatment from 2009 to 2013. On 28 April 2013, he received a kidney transplant. According to the consultants treating him at Manchester Royal Infirmary, the kidney worked well and the Appellant was left with “excellent kidney function”. According to a letter from Dr Morton, Consultant Nephrologist, dated 16 February 2017, a transplanted kidney would be expected to last for ten years or so before it started to deteriorate or fail.



21. Unfortunately, it appears from Dr Morton's letter (which is the most recent medical evidence), the Appellant has developed a number of complications since the transplant. He had a biopsy in August 2016 which suggested a recurrence of his IGA problem in the transplanted kidney. Dr Morton states that there is "little in the way of effective therapies" for the problem other than to continue with immunosuppression. The Appellant takes Prograf as an immunosuppressant. Dr Morton does suggest that steroid therapy might be beneficial but that has not been offered to the Appellant as he also has diabetes. Instead, Dr Morton has prescribed a blood pressure tablet, Lisinopril, which he suggests may protect the kidney function. The Appellant has also developed a virus. Dr Morton points out that, ordinarily, treatment for the virus would be to reduce immunosuppression but that is "not ideal" because of the Appellant's recurrent IGA.
  
22. Dr Morton summarises the future treatment required as follows:-
 

"Mr Hussain does require regular and specialist attention to his kidney transplant and it is anticipated that certainly for the next year or two he will continue to need regular specialised assessments and balancing of immunosuppression against risk of further deterioration or increase in the BK virus infection versus protection against the IGA recurrence."

Dr Morton notes however that the Appellant "otherwise is generally reasonably well and mobile independently with no significant cardio vascular concerns.
  
23. The latter comment sits slightly uncomfortably with the Appellant's assertions in his statement that he is unable to work much as he becomes tired. I note also that those assertions appear to be undermined by other of the Appellant's evidence from friends to whom he provides music lessons, it appears on a frequent and regular basis and who also attest to the Appellant giving regular singing performances.
  
24. Dr Morton lists in his letter the medications which the Appellant currently receives. It appears from what he says in the final paragraph that the most important of those is the immunosuppression drug Prograf. Dr Morton advocates no change in the prescription of that drug. He says that evidence suggests that such a change would lead to "a deterioration in function with a risk of rejection and graft loss which can be life threatening". Dr Morton also confirms, as I indicate above, that the Appellant needs "continued surveillance" in relation to his underlying condition and virus. He concludes that "[f]ailure for these to be provided or find transplant immunosuppression could result in severe or life threatening damage to the transplant and life."
  
25. In terms of evidence of availability of Prograf and follow up care, the Appellant relies on a letter from Captain Dr Ijaz Ahmad Kharal who is said to be an Assistant Professor of Urology at the King Edward Medical University, Mayo Hospital, Lahore. Captain Kharal has apparently been given the Appellant's medical history by Dr Morton. He first says that the need for a specialist organ care centre is "not feasible" in Pakistan. He then says that Prograf "is not available in Pakistan". He goes on to say that routine follow ups and medication monitoring would cost approximately R30,000 (equivalent to about £250) for medicines and R15,000

(equivalent to about £150). That appears to be on a three-monthly basis. Captain Kharal also says that the Appellant would be at risk of getting an infection because of the hot weather in Pakistan. That is not confirmed by any of the other medical professionals who treat the Appellant. It is not clear what level of experience Captain Kharal has in dealing with patients with transplanted kidneys nor what research he has done to form his conclusions about the availability of treatment.

26. Dr Kharal's assertion that Prograf is not available in Pakistan is also confirmed by a letter also dated in 2017 from Fazal Djn Pharmacy. That says that Prograf is "not manufacture[d] in any Pharmaceutical Company in Pakistan and does not exist in Pakistan in any Medical Store or Hospital".
27. I can give little weight to the evidence on which the Appellant relies as to the availability of treatment in Pakistan because it is directly contradicted by evidence produced by the Respondent who has contacted an organisation based in Pakistan which exports and imports pharmaceuticals to that country. That company, Memon Traders, confirms by an e mail dated 31 May 2017 that Prograf is available in Pakistan for Kausar Medicos (which I assume to be a supplier). Memon Traders say that they are unable to deal in the local market but appear to be able to do so if the drug is needed for "pernal" (which I assume to mean personal use). They say the cost for 50 capsules is PKR 3500. That appears though to be the charge to Kausar Medicos. That equates to about £25. That is for a 1mg capsule although the Appellant is prescribed 2mgs twice daily. Fifty capsules would therefore last less than one month (even if the cost put forward is that which the Appellant could expect to pay). A printout from the Pakistan Kidney Patients Association website (see below) produced by the Respondent and dating back to 2009 refers to immunosuppressant medication costing a patient about R13000 to 15000 per month. That evidence is of course somewhat dated.
28. The Respondent has also produced some general COI material about availability of kidney treatment and medication. That dates from 2008 and 2010 and is not directly on point but does confirm that drugs are available for blood pressure and diabetes. The 2008 COI evidence also indicates that essential medicines are in short supply in government health facilities and so most people have to obtain their own medicines from a pharmacy or a dispensing physician. The point is made that medical health insurance is not generally available and that access to basic essential treatments is not available or of limited availability to those living below the national poverty line (said in 2008 to be about 29% of the population). The COI material does however refer to the Pakistan Kidney Patients Association which in 2008 had a centre in Rawalpindi and was at that time "providing a number of services to poor kidney patients to offset the effects of this expensive treatment and improve their quality of life: Free/Subsidized supply of medicines, laboratory services and medical equipment. Such as dialysis kits/dialysis solutions, blood enhancing injections etc. Provision of post transplant immunosuppressive medicines". The COI also points to a number of hospitals throughout Pakistan, public and private, which have nephrology departments providing care for those with kidney disease.

29. The 2010 COI provides information about The Kidney Centre, based in Rawalpindi which stated that it was “dedicated to providing comprehensive preoperative to patients with chronic renal disease, including end-stage renal disease” and that “the Kidney Transplant Program is one component of the full-service Multi-Organ Transplantation Program” at that centre. There is also reference to The Noor Foundation UK which is said to have eighteen “state of the art” kidney dialysis centres across Pakistan located in government hospitals and managed day to day by its NGOs in Pakistan.
30. The evidence produced by the Respondent was supplied very late (31 May 2017) and Mr Schwenk made an application to exclude it. I declined that application, particularly in circumstances where one of the complaints made by the Appellant is that the Respondent has failed to provide evidence of treatment available in Pakistan. It would be wrong to exclude the very evidence which the Appellant says should be provided. I indicated though that, in light of the late provision of this evidence, I would allow the Appellant time to provide evidence to rebut this.
31. Under cover of a letter dated 3 July 2017, the Appellant’s solicitors provided me with a series of e mails which they had sent to the organisations referred to in the COI evidence produced by the Respondent. Those were all dated 19 June 2017. It appears that two of the organisations, the Pakistan Institute of Medical Sciences and Naz Hospital, Lahore are no longer in operation or at least not under those names. The letter indicates that none of the organisations concerned had responded within the two weeks between the e mails and the letter. In the submission of the writer of the letter, “the reluctant attitude of the medical institutes in Pakistan has demonstrated high possibility of him being unable to have access to the medical care that he requires in Pakistan” which would cause “detrimental damage to the appellant’s health and may even result in a life threatening situation for him.”

### Other Evidence

32. In addition to the evidence surrounding the Appellant’s health conditions and availability of treatment for those conditions, I have received statements from the Appellant and a number of supporting letters. As I mention above, the Appellant speaks of his health conditions limiting his ability to work which is undermined to some extent at least by the medical evidence and the statements of his friends. The Appellant also refers to his family in Pakistan. He has a mother, younger brother and younger sister there. His father has passed away. His younger brother is responsible for the maintenance of his mother and younger sister (who is unmarried). His younger brother is a salesman and is earning only just enough to maintain the family he has there. The Appellant says that his younger brother would be unable to afford to pay for him and in particular his medical condition. That the family live in difficult conditions in Pakistan is also confirmed by Mr Jafri who writes one of the letters of support.

33. The letters of support are from the Appellant's friends in the UK. Some have been helping him with accommodation and other living expenses. All speak of his musical abilities and his continuing performances (of Indian classical singing). Most are tutored by the Appellant on a frequent and regular basis. The Appellant is also supported by the Shia Islamic Centre and many of the writers of the letters speak of him as a valued member of the Shia Muslim community in Manchester as well as elsewhere in the country where he is apparently also known because of his singing abilities.

## **Decision and Reasons**

### **Article 3 claim**

34. I indicated at [19] above, that I would consider the Article 3 claim both on the basis of existing domestic case-law and then on the basis that Paposhvili applies.
35. I can deal briefly with the Article 3 claim based on existing domestic case-law. Based on what is said by Laws LJ in GS (which is clearly the most relevant of the domestic cases) as I have set out at [16] above, the Appellant's claim cannot succeed. Indeed, the very fact that the Appellant did not pursue a claim based on Article 3 until following the Grand Chamber's judgment in Paposhvili recognises the futility of such a claim.
36. As I indicate at [9] above, the issue for determination following the Grand Chamber's judgment in Paposhvili is whether there is a real risk of treatment contravening Article 3 ECHR occasioned by the removal. This imports a consideration of the medical evidence about the effect of removal and any changes or deficiencies in treatment of the claimant's medical condition which in turn imports consideration of what treatment is available.
37. In terms of the Appellant's current medical condition, as noted in Dr Morton's letter, that condition is stable and well-managed using the drugs which he is currently prescribed as well as regular monitoring of his condition. Dr Morton in the most recent evidence says that the Appellant is generally well and mobile. I have already rejected the Appellant's evidence that his general health is poor to the extent that he cannot work because he tires easily based both on what Dr Morton says but also the picture painted by the Appellant's friends and supporters which is that the Appellant maintains an ability to teach music and perform.
38. The evidence which the Appellant has presented in support of an assertion that Prograf is not available in Pakistan is unpersuasive, particularly in light of the individualised consideration of its availability in the e mails from an import/export pharmaceutical company in Pakistan produced by the Respondent. Although Dr Kharal's medical credentials are clear on the face of his letter, he does not set out his experience; nor does he say what investigations he has made leading him to the assertion that Prograf is not available. The letter from Fazal Djn Pharmacy is

unimpressive. Not only is the assertion there made undermined by the e mails which the Respondent has produced but the letter itself does not even give the name of the person who provides this information let alone any information about how the writer is proficient to give this opinion or on what information/research it is based. I therefore find as a fact that Prograf is available. The Appellant does not provide any evidence that the other medication which he is taking is not available in Pakistan.

39. The second question concerns the monitoring of the Appellant's condition. Although Dr Kharal says that a "specialist organ care center" in Pakistan is "not feasible", it is clear that there are facilities offering services for those with kidney problems. The fact that Dr Kharal is himself an Assistant Professor of Urology at a hospital in Lahore shows that care is available for kidney conditions. Dr Kharal has provided an estimate of the cost of follow up treatment and medicines which together appear to equate to about £400 every three months.
40. The Respondent has also provided evidence of other institutions throughout Pakistan including a centre in Rawalpindi offering some free services for those with kidney problems who are unable to pay for care. That is not one of the institutions which the Appellant says in submissions in reply is no longer in existence.
41. I am unimpressed by the submission made in response to the Respondent's evidence that, simply because those institutions did not respond to e mails within a few weeks suggests that the Appellant would not be able to access them for treatment. The e-mails are written by the Appellant himself who explains his condition, says he is resident in the UK and has been receiving free medical care, asserts that he will have to return to Pakistan within the next two weeks (which is untrue) and says that he cannot afford to pay for treatment and monitoring as he is too ill to work (which evidence I have already rejected). He therefore asks how he could get access to free medical care or for an estimate of cost for treatment and how he might access the Patient Welfare Programme.
42. This is not an e mail from solicitors asking for those institutions to provide evidence as to their services for the purposes of these proceedings as one might have expected nor is any deadline provided for a response to the e mail. These are no doubt health facilities who are busy taking care of patients and might expect that if the writer of the e mail is going to be returning to Pakistan as he says, could go along to their facilities and find out for himself what treatment is available. In the absence of evidence undermining the Respondent's evidence or suggesting that it is outdated (other than that two of the facilities are no longer operating), I accept that evidence.
43. The Appellant has family in Pakistan. I appreciate that he says that his younger brother who works cannot afford to pay for the Appellant's treatment because he has his mother and younger sister to care for. The Appellant's brother earns approximately R25,000 which the Appellant says is just sufficient to cover the family's expenses. He does not though say that he could not live with his family. I have already explained why on the totality of the evidence, I consider the

Appellant's assertions that he is unable to work much due to ill-health to be exaggerated. What he says in his statement is that he cannot sing "for too long due to [his]medical conditions" and that "he often feels weak". He says that being an entertainer in Pakistan is a low-ranking job and is not well paid. He says he would earn about R1000 per performance (one to one and a half hours). Even if he is unable to work full-time though, even on his own evidence, he is not prevented from working at all by his health condition and he does not say that work is unavailable in Pakistan. On that basis, I reject the Appellant's evidence that he would not be able to afford to pay for or at least contribute to the cost of his treatment.

44. For those reasons, I find that the Appellant has not demonstrated that there is a real risk of a breach of Article 3 on return to Pakistan. He has not shown that his health will suffer to any marked degree provided that he continues to receive appropriate medication and monitoring. The main drug which the doctors here say is essential to him is available in Pakistan for a cost which would be affordable if the Appellant works and I have indicated why I do not accept that he cannot do so. He can live with his family. Even if, as he asserts, his brother cannot afford to help out with the cost of treatment, the Appellant would not have to contribute to the cost of accommodation nor possibly even such things as food (given that the Appellant's brother is already having to fund living expenses for two other members of the family). On the basis of what is said to be available in Pakistan and the cost put forward generally for medication and follow up treatment, the Appellant is likely to be able to afford access to that treatment. The Respondent has provided evidence which I find persuasive of treatment which is likely to be available to the Appellant irrespective of cost if he is unable to pay for it.

#### Article 8 claim

45. As the Court of Appeal observed in GS, if an Article 3 claim fails, "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 observation is not affected by the Grand Chamber's judgment in Paposhvili.
46. GS is however concerned with decisions made before the change in the Immigration Rules on 9 July 2012 and therefore outside the Rules. The Appellant says that his case meets paragraph 276ADE(1)(vi) namely that there are "very significant obstacles to his integration" in Pakistan.
47. I start by noting that paragraph 276ADE(1)(vi) concerns a claim based on a person's private life. As such, the observations made by the Court of Appeal in GS still have some relevance. This remains about obstacles to integration and therefore disruption to private life. Further, the threshold set by paragraph 276ADE(1)(vi) remains a high one (see by way of example the Court of Appeal's approval of the Upper Tribunal's adoption of those propositions in Secretary of State for the Home Department v Kamara [2016] EWCA Civ 813). This claim fails on both counts. Whilst the threshold

for what are “very significant obstacles” in the context of Article 8 (which is a qualified right) is not to be equated with whether there is “a real risk” of ill-treatment in the context of Article 3 (which is an absolute right), it remains a high threshold and one which, in terms of the medical health claim, has to be considered against the same evidence.

48. Further, and in any event, this provision is about obstacles to integration (and disruption to private life) not obstacles to accessing medical treatment per se. Whilst I can conceive of cases where lack of access to medical treatment could on its own have a sufficient impact on an ability to integrate where, say, a person does not have any ties in the country of return and would be unable to form any due to an illness, that is not this case. The Appellant has family in Pakistan to whom he can turn. It is also clear from evidence from his friends that the Appellant has retained cultural ties to his home country. His friends talk of him being a “valued member of the Muslim community”. His performances involve recitations of religious hymns in a choir. He is said to be a “well known member of the Shia Muslim community throughout the UK, commonly appearing on TV channels”. For those reasons, I find that there are no very significant obstacles to the Appellant’s integration in Pakistan.
49. Finally and for the sake of completeness, I deal with Article 8 outside the Rules. As I observe at [13] above, a submission that the Appellant could succeed outside the Rules on the basis that the interference with his private life could outweigh the public interest was not pressed with any great enthusiasm and rightly so. There can be no dispute that the Appellant’s Article 8 rights are engaged or sufficiently interfered with to require justification. The Appellant is a single man without family in the UK who has however been here since (on his last arrival) 2004, some thirteen years ago and has formed friendships. It appears that he arrived initially as a work permit holder (and had also been in the UK previously as a performer in 2002 but returned to Pakistan). His friends speak of him with affection and respect in their statements. I have dealt above with his ties to his community in the UK.
50. As noted above, the Appellant initially came to the UK as a work permit holder in 2004. It is not clear when his leave in that category expired but, according to the Respondent’s skeleton argument, he has overstayed for part of the time. His status at that time was in any event not settled. Further submissions were made and rejected in 2009. In 2011, an application was made for him to remain on the basis of his medical condition which had developed whilst in the UK. He was granted three years’ discretionary leave to remain until 2015. It is the refusal of the application for further leave which is the subject of this appeal. The Appellant’s residence throughout the past thirteen years is therefore in part unlawful and in part precarious.
51. I have regard to section 117B Nationality, Immigration and Asylum Act 2002. The Appellant has no basis of stay under the Immigration Rules (once his claim to remain based on paragraph 276ADE(1)(vi) is rejected). It is clear from the medical evidence in this case that the Appellant has received a substantial amount of free health care

on the NHS including dialysis and a kidney transplant. The Appellant is not to be blamed for that (he did not come to the UK seeking medical treatment) but it is relevant to the public interest balance. That the Appellant's status is and has always been precarious and that he has no basis of stay under the Rules also lie in favour of the public interest in removal. Maintenance of immigration control is in the public interest and I can give little weight to the Appellant's private life formed whilst he has not had settled status. I do not know if he speaks English. He appears to have formed friendships within the Muslim community but that is not to say that he does not speak English. The fact that he has maintained those ties both linguistic and cultural though does mean that he will be able to more readily adapt to life in Pakistan where, as I have already observed he has family ties.

52. The main factor weighing in favour of the Appellant being permitted to remain in the UK is his medical condition. However, I have already explained why, based on evidence of his condition currently as well as the treatment available in Pakistan, there is no real risk of a breach of Article 3 ECHR. Based on the same evidence, and having regard to the public interest in removal to which I have referred above, I am satisfied that such interference as there will undoubtedly be with his private life including his medical care by removal to Pakistan is proportionate.

**DECISION**

**The Appellant's appeal is dismissed on human rights grounds and under the Immigration Rules**



Signed

Dated: 5 October 2017

Upper Tribunal Judge Smith





Upper Tribunal  
(Immigration and Asylum Chamber)

Appeal Number: IA/19553/2015

**THE IMMIGRATION ACTS**

Heard in Liverpool  
On Tuesday 17 January 2017

Determination Promulgated

.....

Before

UPPER TRIBUNAL JUDGE SMITH

Between

MR AMMAR HUSSEIN

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

**Representation:**

For the Appellant: Mr Schwenk, Counsel instructed by Arshed and Co solicitors

For the Respondent: Mr Harrison, Senior Home Office Presenting Officer

**ERROR OF LAW DECISION AND DIRECTIONS**

**DECISION AND REASONS**

**Background**

1. The Appellant is a national of Pakistan who appeals against the Respondent's decision dated 6 May 2015 refusing him further leave to remain under Article 8 ECHR on

the basis of his medical condition and the private life he has formed since arriving in the UK last in 2004. The refusal of leave to remain followed the grant of a period of discretionary leave in 2012. His appeal against that decision was dismissed by First-tier Tribunal Judge G D Tobin in a decision promulgated on 9 May 2016 (“the Decision”) on the basis that there were “no insurmountable obstacles” to the Appellant returning to Pakistan to continue his medical treatment and there was no reason to allow the appeal outside the Rules.

2. The focus of the appeal and the Decision is the Appellant’s medical condition. He has undergone a kidney transplant in the UK. He continues to receive treatment and medication to maintain his health. The Appellant’s solicitors have submitted a recent letter from Dr M Morton, the Appellant’s consultant nephrologist, which suggests that the Appellant’s condition has recently deteriorated but that evidence post-dates the Decision and at this stage, I leave it out of account. The Judge found in the Decision that the Appellant had failed to demonstrate that the medication which he receives is not available in Pakistan. The Judge accepted that medical care in Pakistan may not be of the same standard in the UK nor universally free at the point of access. Nonetheless, the Judge found at [24] of the Decision that the Appellant could access appropriate medication.

3. Permission was granted by First-tier Tribunal Judge Pullig on 19 September 2016 on the basis that the Judge may have erred in taking into account evidence relating to medication used to treat those who have undergone liver transplants rather than a kidney transplant. In relation to the remaining grounds, since those raised the issue of whether there would be “very significant obstacles” to the Appellant’s reintegration in Pakistan, those stood or fell with the ground relating to sufficiency of treatment in Pakistan. The appeal comes before me to decide whether the Decision contains an error of law and if so to either re-make the decision or remit the appeal to the First-tier Tribunal for redetermination.

### The Rules

4. The Appellant cannot meet the Rules in relation to leave to remain based on his private life unless he can satisfy paragraph 276ADE(1)(vi). Paragraph 276ADE(1)(vi) reads as follows:-

**“Requirements to be met by an applicant for leave to remain on the grounds of private life**  
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:

.....

(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 if required to leave the UK.

### Discussion

8. Mr Schwenk relied on the Appellant's grounds save in relation to one additional point with which I deal at [13] below. The first issue relates to whether the Judge erred at [19] to [20] of the Decision in the reference to evidence concerning liver transplant medication which was not relevant to the case and therefore whether he erred in his conclusion at [20] that "liver transplant medication is readily available in Lahore, at least." I pointed out that this referred to what was produced to the Judge by the Respondent (referred to at [19] of the Decision). It was apparent that neither Mr Schwenk nor Mr Harrison had sight of those documents. I therefore gave them both the opportunity to consider the two documents which I had read. Those documents consist of two internet searches. The first relates to the availability of medication, including Prograf which is the focus of the Appellant's case that suitable medication is not available. The second relates to a health care centre in Lahore which (in its own words) "helps patients undergo liver transplant surgery successfully."

9. I indicated to the parties my view that there was no error made by the Judge at [20] in the reference to liver transplants rather than kidney transplants. This did not appear to me to be a slip or typographical error. What the Judge was referring to was the only real evidence which he had relating to treatment for transplant patients, namely that one of the drugs which the Appellant says he could not obtain in Pakistan is clearly available (albeit probably at a cost) and that there are centres which help liver transplant patients and one might therefore expect that they would be able to help patients who have undergone other organ transplants.

10. That evidence stood to be considered against what the Appellant himself put forward which the Judge dealt with at [10] of the Decision. That evidence amounted to two documents emanating from Pakistan. Those are summarised by the Judge as being "a letter certifying that a specified drug is not available in Pakistan (on untranslated notepaper) and another letter from Fazal Din Pharmacy, Lahore, Pakistan certifying that a specified drug is not available in Pakistan." Mr Schwenk accepted that this was the only evidence produced by the Appellant and (subject to one point to which I refer below at [13]) that the burden of making out his case based on human rights lay with the Appellant. I do not accept therefore that the reference to liver transplants rather than kidney transplants amounted to an error by the Judge.

11. Based on the two internet searches, however, Mr Schwenk challenged the Judge's findings further for the following reasons. First, he pointed out that the first referred only to the medication available. That makes no reference to what treatment would be available. Second, in relation to the information about the health centre, he pointed out that this is a private clinic and one of the points made by the Appellant is that he would be unable to afford treatment. Mr Schwenk directed my attention to the wealth of evidence from those treating the Appellant in the UK about the need for not simply medication but also regular checks and specialist treatment. Without that, the Appellant's health would deteriorate. The Judge, he said, had failed to analyse that evidence.

12. Mr Schwenk also sought to introduce a further ground following the recent Grand Chamber case of Paposhvli v Belgium (Application No 41738/10). Mr Schwenk readily accepted that this was a case raising Article 3 ECHR, that the Appellant's case before the

First-tier Tribunal relied only on Article 8 ECHR and that had he been presenting the case before the Judge at that stage, he too would have relied only on Article 8. He submitted however that the landscape has changed as a result of Paposhvli both procedurally and substantively. By reference to what is said at [189] to [190] of the Court's assessment, he submitted that this Appellant's case is at least potentially a case to which Article 3 could apply and that the burden of showing what treatment would be available is no longer simply on the Appellant.

13. Mr Schwenk of course accepted that this was not one of the Appellant's pleaded grounds - Paposhvli post-dates both the grounds and the grant of permission by a number of months. He also accepted that the position at first instance in that case had followed the previous line of judgments such as N v UK. He also accepted that the First-tier Tribunal Judge could not have been expected to follow that decision since it post-dated the hearing. He submitted however that the point was now "Robinson obvious" for me when considering what he said was the Judge's error in placing the burden on the Appellant to show that suitable medication and treatment would not be available in Pakistan. That was notwithstanding that the Appellant's case was pursued only under Article 8 ECHR and therefore Paposhvli is not directly on point. I observe also in passing that the Grand Chamber's decision also makes clear at [186] that the initial burden at least lies with the Appellant to show that there are substantial grounds for believing that he would be at real risk of ill treatment contrary to Article 3 ECHR on return.

14. I had some difficulty following Mr Schwenk's submission that Paposhvli is of such relevance and import to the Appellant's case that it discloses an error of law in the Judge's approach on a clear and obvious basis. In my view, his submission goes nowhere near establishing the sort of clear and obvious point which could be said to be "Robinson obvious".

15. However, I do not need to decide the point as the remainder of Mr Schwenk's submissions persuade me that there is an error of law in the Decision and Mr Harrison concedes as much.

16. Firstly, I accept Mr Schwenk's submission recorded at [11] above that the Judge has failed to deal adequately with the evidence which there was about the treatment which the Appellant requires as opposed to simply the medication. There is a wealth of evidence produced by the Appellant about the treatment which he receives post his transplant operation. That confirms the need for ongoing specialist treatment to maintain his health (even leaving aside the recent deterioration in his condition).

17. Secondly, Mr Schwenk drew my attention to the manner in which the Judge has dealt with the question of whether there are "very significant obstacles" for the purposes of paragraph 276ADE(1)(vi) and Article 8 more generally. Mr Schwenk pointed out that at [23] of the Decision the Judge has failed to note the other evidence relating to the private life which the Appellant has formed in the UK during his thirteen years of residence. Whilst I did not understand Mr Schwenk to submit that this would of itself permit the Appellant to remain, that evidence had to be coupled with the evidence in relation to the

Appellant's medical condition when dealing with Article 8 more generally. Mr Schwenk pointed out that, although at [5] and [22] of the Decision the Judge has correctly directed himself to the test of "very significant obstacles", at [25] when looking at Article 8 in the round, he has resorted to a test of "insurmountable obstacles" which is incorrect.

18. Mr Harrison for the Respondent conceded that there is an error in relation to the point recorded at [17] above. He accepts that "insurmountable obstacles" relies on the wrong test. He also accepted however in light of that concession that Paposhvli may have an impact on this case and would be a factor to be taken into account going forward. He also indicated that, given the complexities of the case, the Decision is a short one and fails to adequately deal with some of the evidence. He therefore conceded that the Decision does disclose a material error of law.

19. Both parties agreed that the appeal can remain in the Upper Tribunal for re-making. This is not a case which turns on any issues of credibility. As is evident from the foregoing, however, more evidence will be required (potentially from both parties) in relation to the availability of treatment and medication in Pakistan. The parties' legal submissions also need to take into account the case of Paposhvli and, particularly since this was raised only at the hearing, the Respondent will need to consider its relevance. Mr Schwenk also asked to be able to raise Article 3 in light of that case. I indicated that I would not restrict him doing so in his further legal submissions (provided of course that those are pleaded in his written submissions so that the Respondent has the opportunity to deal with them). For those reasons, I agreed directions with the parties which are set out below to lead to a resumed hearing for the re-making of the Decision.

## DECISION

**The First-tier Tribunal Decision did involve the making of an error on a point of law. I set aside the Decision**

**In relation to the re-making of the decision, I make the following directions:-**

- 1. By 4pm on Friday 17 March 2017, the Appellant shall file and serve any additional evidence on which he wishes to rely in relation to the re-making of the decision. That must include but is not limited to an updating of evidence in relation to his medical condition and the availability of treatment and medication in Pakistan.**
- 2. By 4pm on Friday 17 March 2017, the Appellant shall also file and serve a skeleton argument setting out his submissions on the legal issues for the re-making of the decision. For the avoidance of doubt, the Appellant is permitted (if so advised) to amend his grounds of challenge to include reliance on Article 3 ECHR.**
- 3. By 4pm on Tuesday 18 April 2017, the Respondent shall file and serve any additional evidence on which she wishes to rely in relation to the re-making of the decision. That must include but is not limited to evidence concerning the availability of treatment and medication for the Appellant's condition in**

**Pakistan. By the same date, the Respondent shall file and serve a skeleton argument responding to the Appellant's skeleton argument.**

- 4. The appeal will be listed for a further oral hearing after 2 May 2017 in either Manchester or Liverpool with a time estimate of three hours. It is anticipated that the hearing will consist of oral submissions only and that there will not be a need for oral evidence. However, if the Appellant wishes to give oral evidence and an interpreter is required, the Appellant's solicitors shall, no later than fourteen days prior to the date listed for hearing notify the Tribunal that an interpreter is required.**
- 5. The parties may apply to the Tribunal on notice to the other party if they seek a variation of these directions or any additional directions.**



Signed

Dated: 19 January 2017

Upper Tribunal Judge Smith