



Upper Tribunal

(Immigration and Asylum Chamber)

Appeal Number: UI-2022-003079

HU/07272/2020

THE IMMIGRATION ACTS

**Decision & Reasons Issued:
On the 16 March 2023**

Before

**THE HON. MRS JUSTICE THORNTON
UPPER TRIBUNAL JUDGE RIMINGTON**

Between

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Appellant

and

**RAMANDEEP SINGH DHALIWAL
(ANONYMITY DIRECTION NOT MADE)**

Respondent

Representation:

For the Appellant: Ms Cunha, Senior Presenting Officer, Home Office

For the Respondent: Mr M Moriarty, instructed by Tuckers Solicitors.

Heard at Field House on 12 December 2022

DECISION AND REASONS

Introduction

1. The Secretary of State appeals against the decision of the First Tier Tribunal, dated 17 May 2022, upholding Mr Dhaliwal's appeal against her decision, dated 14 July 2020, to refuse his protection and human rights claim, and making an order for his deportation. For ease of reference, the parties are referred to as they were before the First Tier Tribunal

(namely, references to the Appellant are to Mr Dhaliwal and references to the Respondent are to the Secretary of State).

2. The Appellant is a national of India, issued with indefinite leave to remain on 13 April 2011. He was convicted for conspiracy to pervert the course of justice and conspiracy to commit false imprisonment on 11 December 2017 and sentenced to 8 years and 6 months imprisonment.
3. In seeking to resist deportation, the Appellant advanced a claim for asylum on the basis of a well-founded fear of persecution in India on the basis of his involvement in a land dispute in India and fear of reprisals. The Secretary of State refused the asylum claim on the basis the Appellant had failed to rebut the presumption under section 72(5A) of the Nationality Immigration and Asylum Act that, having been convicted of a particularly serious crime, he constituted a danger to the community of the UK. In addition, his claim for protection under Articles 2 and 3 ECHR on the basis of the land dispute was not accepted. These decisions, upheld by the FTT judge, have not been challenged and accordingly, we say no more about them.
4. The Appellant also advanced before the Secretary of State an Article 3 claim based on ill health, namely thyroid and mental health problems. The Secretary of State rejected the claim and the refusal letter details her reasons, based on these grounds. Subsequently, whilst in prison, the Appellant was diagnosed with Eosinophilic gastroenteritis, a rare autoimmune/gastroenterological condition. It is this condition that forms the basis of the Article 3 claim which succeeded before the FTT and which is challenged by the Respondent. This, therefore, is the medical condition which forms the focus of our decision.
5. The Secretary of State consented to the new medical claim being advanced before the FTT but did not issue a supplemental decision letter addressing the new basis for the claim. This was despite her presenting officer considering a supplemental decision was necessary and despite the fact that the appeal before the FTT was adjourned on two occasions, on the day of the hearing, at the request of the Secretary of State, due to the volume and complexity of material. The hearing eventually proceeded on 22 April 2022, by way of CVP.

The First Tier Tribunal decision

6. The FTT Judge addressed the medical claim based on the Appellant's diagnosis of Eosinophilic gastroenteritis as follows:
 25. *Moving on to the Article 3 medical claim and whether there is a serious, rapid and irreversible decline in the state of health resulting in intense suffering or a significant reduction in life expectancy. The Appellant must show there is evidence which is capable of demonstrating "substantial" grounds for a very exceptional case because of the real risk of inhuman treatment, and once the Appellant*

has shown a prima facie case of potential infringement of Article 3, the burden shifts to the Respondent to counter this, and failure to do so establishes an infringement of Article 3. The representatives agreed at the start of the hearing that we could proceed in the absence of a supplementary decision letter.

26. *The medical evidence from Dr Ian Johnston Consultant Gastroenterologist confirms. (a) Eosinophilic gastroenteritis is a rare autoimmune/gastroenterological disease. It cannot be cured but can be managed through dietary therapy and medications. Management of the condition by a gastroenterologist is crucial. (b) It is a complex condition that will require ongoing monitoring and treatment. He will need access to MRI and CT scans, endoscopy and doctors from other specialities. (c) He may need very regular blood tests, up to 2 weekly and therefore his gastroenterologist should be local to him. (d) The condition does occur in patients with allergies, the underlying cause is most likely related to food allergies. (e) The appellant continues to suffer allergic reactions, namely swelling in his throat, eyes and lips, abdominal bloating and feeling unwell when eating certain food. Following advice to follow an elimination diet by Adult Allergy Specialist Dietitian, Liane Reeves, Dr Johnstone advised the more aggressive full 6 food elimination diet should be followed. (f) Allergic reactions can be severe or life threatening. (g) A very severe case can result intestinal failure. Deaths have been reported in the condition. (h) The appellant's medical condition is a serious one, not just an unpleasant illness. It is potentially life - threatening if he does not receive ongoing specialist gastroenterology and immunological care in a centre with access to up-to-date interventions and radiological procedures available. (i) Investigation of both the Eosinophilic Gastroenteritis and food allergy continues. Long term medication is likely to be required. (j) Continuity of care is important and any significant break in his care will be detrimental to his health affecting his ability to get out of the house to live and work. It may require hospitalisation for emergency treatment and tests.*

...

28. *As for the availability or accessibility of such regular, specialist, multidisciplinary, modern facilities. Dr Ashok Sharma, of Sharma Hospital & Multi Speciality Medical Centre, being the appellant's family physician confirms: (a) The disease is very rare in Punjab State; (b) He has never come across the condition in his clinical practice; (c) The appellant would require very specialised gastro treatment at Tertiary Care Centre, which would be very expensive.*

29. *The Respondent's CPIN India: Medical and healthcare provision, October 2020 speaks generally as to healthcare provision in India and although is specific on healthcare provision in a number of areas such as oncology and cardiology the guidance is silent on*

*gastroenterology and immunology. Reference to the CPIN alone is insufficient to discharge the procedural requirement set out above. What is clear, even on a general basis is that the Public (state) sector tertiary level super specialist centres that would be required to treat the appellant's condition costs are not free but subsidized, and as Dr Sharma highlighted even these would be very expensive. The only alternative being the private sector, the cost of which would be even more. The appellant has encountered significant difficulties in trying to obtain precise costings for all the elements of his monitoring and treatment needs, since every aspect of care is charged for on individual basis, institutions do not provide publicly available price lists for every aspect of investigation and treatment required and institutions are reluctant to confirm any costs without seeing the appellant as a patient. The appellant has given a rough estimate of costs based on his procedures, tests and treatment performed in the UK and from outdated 2014/15 and patchy prices. The estimate does not take medication, immunology consultation and treatment, local GP costs, emergency treatment and travel into account and already is estimated at over £7500. This scenario is exactly what the Supreme Court in **AM (Zimbabwe)** identified as being the reasoning behind the shift in burden to the Respondent, since she is better placed to obtain this precise information in the receiving state.*

30. *I prefer the medical evidence that was presented to me which is more than the Respondent's submission which is that just because the condition is very rare does not mean it is not easily treatable. Whilst the treatment the Appellant receives is basic and readily available because it consists of antiacid and to date he has had his three courses of steroids, the difficulty with this submission is that it does not see the condition as evolving, and one which needs very close monitoring and because the Appellant has faced and will face life threatening attacks requiring emergency hospitalization, I conclude when considering the evidence in the round, the Appellant has at today's date provided a prima facie case.*

31. *I turn now to consider whether the test of whether the public interest in deportation can only be outweighed by very compelling circumstances having regard to all the facts of the case as set out above in great detail and including the Article 3 medical issue which is tied to the date of the hearing and which is of its nature an evolving condition which requires new and evolving treatment.*

32. *I conclude that the public interest in the deportation of the Appellant remains very high, and but for the Article 3 issue the Appellant would have been removed, and when looking at the case in the round, I find that there are compelling circumstances in the current and immediate need for the Appellant to continue his treatment for his condition in the UK by his medical team, but that it is not 'very compelling circumstances' because the nature of the condition is one that is evolving as is the medical knowledge and*

understanding of it, and the Article 3 claim prevents removal today because the monitoring of the Appellant can as of today's date be done in the UK, but that does not prevent a review in the not too distant future of the doctors acquiring a greater understanding of and ability to treat his condition such that he can return to his country and I dismiss the aspect of the appeal on deportation and only allow the appeal on Article 3 medical grounds.

Legal framework for Article 3

8. There was no dispute as to the relevant legal framework to resist return on grounds of ill-health pursuant to Article 3 of the European Convention on Human Rights. The framework is conveniently summarised by the Supreme Court in AA (Zimbabwe) v Secretary of State for the Home Department [2020] UKSC 17 as follows:

32. ... The basic principle is that, if you allege a breach of your rights, it is for you to establish it. But "Convention proceedings do not in all cases lend themselves to a rigorous application of [that] principle ...": DH v Czech Republic (2008) 47 EHRR 3, para 179. It is clear that, in application to claims under article 3 to resist return by reference to ill-health, the Grand Chamber has indeed modified that principle. The threshold, set out in para 23(a) above, is for the applicant to adduce evidence "capable of demonstrating that there are substantial grounds for believing" that article 3 would be violated. It may make formidable intellectual demands on decision-makers who conclude that the evidence does not establish "substantial grounds" to have to proceed to consider whether nevertheless it is "capable of demonstrating" them. But, irrespective of the perhaps unnecessary complexity of the test, let no one imagine that it represents an undemanding threshold for an applicant to cross. For the requisite capacity of the evidence adduced by the applicant is to demonstrate "substantial" grounds for believing that it is a "very exceptional" case because of a "real" risk of subjection to "inhuman" treatment. All three parties accept that Sales LJ was correct, in para 16, to describe the threshold as an obligation on an applicant to raise a "prima facie case" of potential infringement of article 3. This means a case which, if not challenged or countered, would establish the infringement:

33. In the event that the applicant presents evidence to the standard addressed above, the returning state can seek to challenge or counter it in the manner helpfully outlined in the judgment in the Paposhvili case at paras 187 to 191 and summarised at para 23(b) to (e) above. The premise behind the guidance, surely reasonable, is that, while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state. What will most surprise the first-time reader of the Grand

Chamber's judgment is the reference in para 187 to the suggested obligation on the returning state to dispel "any" doubts raised by the applicant's evidence. But, when the reader reaches para 191 and notes the reference, in precisely the same context, to "serious doubts", he will realise that "any" doubts in para 187 means any serious doubts. For proof, or in this case disproof, beyond all doubt is a concept rightly unknown to the Convention.

9. The reference to paragraph 23 (b) to (e) of the judgment (in turn a reference to the European Court of Human Rights case of Paposhvili v Belgium and the obligations on receiving states) is as follows:

(b) ... that, where such evidence was adduced in support of an application under article 3, it was for the returning state to "dispel any doubts raised by it"; to subject the alleged risk to close scrutiny; and to address reports of reputable organisations about treatment in the receiving state;

(c) ... that the returning state had to "verify on a case-by-case basis" whether the care generally available in the receiving state was in practice sufficient to prevent the applicant's exposure to treatment contrary to article 3;

(d) ... that the returning state also had to consider the accessibility of the treatment to the particular applicant, including by reference to its cost if any, to the existence of a family network and to its geographical location; and

(e) ... that if, following examination of the relevant information, serious doubts continued to surround the impact of removal, the returning state had to obtain an individual assurance from the receiving state that appropriate treatment would be available and accessible to the applicant.

The Respondent's Grounds of Appeal

10. The Respondent advanced the following grounds of appeal:

- The FTTJ erred in finding that Article 3 is breached. Article 3 on medical grounds has a very high threshold and is applicable in exceptional cases. The appellant's case does not meet this threshold. The appellant has not provided evidence capable of demonstrating that there are "substantial" grounds for believing that he would be exposed to a real risk of being subject to "inhuman" treatment contrary to Article 3.
- It is unclear whether the FTTJ has considered all the medical evidence relied upon by the Respondent, in particular the evidence in its decision that India has a 'vast healthcare system', there are 'relatively low costs' and 'high quality'. The private sector plays an

important role in India's healthcare delivery. insurance is available. Private hospitals in India offer world class quality health care at a fraction of the price of hospitals in developed countries.

- The family physician has only made comment on Punjab State and their evidence is that treatment is available but that it would be expensive. The onus is on him to demonstrate that he would not be able to access this treatment. The appellant is described as 'highly educated', has previously run a business, and his partner is employed as a Programme Officer with an annual salary of £46,636. He cannot be described as 'poor' and that there is an option for him to pay for treatment or obtain insurance. Therefore, the appellant has not adduced evidence "capable of demonstrating" that "substantial grounds have been shown for believing" that as "a seriously ill person", he "would face a real risk": [i] "on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, [ii] of being exposed [a] to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering, or [b] to a significant reduction in life expectancy".

Discussion

11. There is no challenge to the FTT Judge's recitation of the relevant legal framework at paragraph 25 of her decision.
12. At the start of the hearing we asked the representatives to direct us to the evidence which formed the basis of the Judge's conclusions at paragraphs 26 - 30 of the decision.
13. The Appellant's evidence includes the following:
 - a. letters from the NHS consultant treating the Appellant for his condition (including letters dated 19/09/21 and 14/1/22);
 - b. email exchanges between the treating consultant and the Appellant/his solicitors (including emails dated 22/4/21; 22/9/21; 23/9/21; 20/1/22 and 21/1/22);
 - c. a letter from an Adult Allergy Specialist Dietician treating the Appellant (dated 6/12/21);
 - d. a letter from the Appellant's family physician in the Punjab State stating that he has never come across the disease and that treatment will be required at a Tertiary Care Centre which would be very expensive;
 - e. a letter from Benenden Health Care indicating the Appellant has private health care insurance;

- f. research by the Appellant/his solicitors into potential treatment costs at gastroenterology hospitals in India.
14. On behalf of the Respondent, Ms Cunha pointed us to the information in the refusal letter dated 14 July 2020 about the medical facilities available in India, which include references to the high quality of private hospitals; the relatively low costs and the important role played by private sector in India's healthcare delivery.
15. We have considered the evidence carefully. Having done so, we have come to the conclusion that the FTT judge has erred in her consideration of the Appellant's evidence by failing to consider relevant material and further failing adequately to explain how the appellant can meet the demanding threshold of being capable of demonstrating that there are substantial grounds for believing that article 3 would be violated.
16. At paragraph 26 of the decision, the Judge summarises the medical evidence from the treating consultant. She does not however acknowledge or address the evidence of the doctor that whilst the Appellant has a rare and complex condition which cannot be cured, it can be successfully managed through a combination of dietary therapy and medications (email from the consultant to the Appellant dated 20/01/2022 ... *I would not expect eosinophilic enteritis to be cured but it can be successfully managed through a combination of dietary therapy and medications*). In addition Ms Cunha pointed us to an email, dated 22/04/2021, from the treating consultant to the Appellant's Solicitors, which included the following statement: ... *The course of this condition can be variable between different patients but in general most patients will respond to a course of steroids. Assuming that he maintains a good response to the steroids I would not suspect any long-term sequelae of the condition*. In these respects, the Appellant's own evidence runs counter to the Judge's finding at paragraph 30 of the decision that '*I prefer the medical evidence that was presented to me which is more than the Respondent's submission which is that just because the condition is very rare does not mean it is not easily treatable.*'
17. The Judge considers the availability and accessibility of the specialist treatment required at paragraph 28 of her decision. She does so by reference to the evidence from the family physician that the disease is rare in the Punjab state, that he has never come across the condition and the appellant would require specialised gastro treatment which would be expensive. The Judge does not however acknowledge or address the evidence of the treating consultant that he would expect any fully qualified gastroenterologist with access to modern facilities, investigation and treatment to be able to manage the condition, regardless of their previous experience in the disease (email dated 20/1/22 to the Appellant *I would however expect any fully qualified gastroenterologist with access to modern facilities, investigation and*

treatment to be able to manage your condition, regardless of their previous experience in the disease).

18. In addition, whilst the Judge refers to the expense of treatment, she does not refer to the evidence indicating that the Appellant has private medical insurance. In this context, Mr Cunha emphasised the relevant country information which includes reference to the high quality of private hospitals in India; the relatively low costs and the important role played by private sector in India's healthcare delivery.
19. In clear and succinct submissions on behalf of the Appellant, Mr Moriarty submitted that the Secretary of State's grounds of appeal conflate the initial burden on the Appellant in Article 3 claims with the consequential burden on the Respondent, in circumstances where the Respondent's evidence is insufficient to discharge her obligation. It was, he submitted, entirely open to the Judge to accept that there are substantial grounds for believing that, on removal, there is a real risk of treatment contrary to Article 3 such that the Appellant had discharged his burden under article 3. The Secretary of State was, he submitted, now seeking to reargue the appeal having been given every opportunity to adjourn the FTT hearing but electing not to provide a supplemental response which is not the fault of the appellant or the First Tier Tribunal.
20. For the reasons given above we do not accept Mr Moriarty's submission that it was open to the Judge to conclude that the Appellant had discharged the burden on him to establish the Article 3 claim. It is therefore not necessary, for the purposes of disposing of this appeal, to consider the Respondent's evidence. We make the observation, however, that the Respondent's evidence is thin, based as it is, on information in a refusal letter responding to a different medical condition. We are also inclined to accept the force of Mr Moriarty's complaint about the absence of a supplemental decision letter, which, in our view, is likely to have hampered the Judge in her consideration of matters.

Relief

21. Accordingly, we conclude that there is a material error of law in relation to the Article 3 claim (diagnosis of Eosinophilic gastroenteritis) and the FTT decision should be set aside, in this respect. We consider it appropriate to remit the matter to the FTT for a re-hearing before a different judge. In the absence of a supplemental decision letter and to assist the Judge at the rehearing, we direct the Secretary of State to serve a skeleton argument in advance of the hearing setting out her position on the Article 3 claim in relation to the Appellant's diagnosis of Eosinophilic gastroenteritis.

Notice of Decision

22. The appeal is allowed. The decision is set aside in relation to the decision on Article 3 (ill health based on diagnosis of Eosinophilic gastroenteritis) with no findings preserved (namely paragraphs 25-30 and the consequential aspects of paragraphs 31 and 32) and remitted to the FTT for rehearing. All other findings in the decision are preserved. No anonymity direction is made.

Signed: THE HON. MRS JUSTICE THORNTON DBE Date: 17 January 2023

The Hon. Mrs Justice Thornton DBE sitting as an Upper Tribunal Judge.