Neutral Citation Number: [2013] EWCA Civ 1251

Case No: C4/2013/1314

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT (COX J)
REF: CO1332/2013

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/10/2013

Before :

LORD JUSTICE MAURICE KAY, Vice President of the Court of Appeal, Civil Division
LORD JUSTICE LEWISON
and
LORD JUSTICE UNDERHILL

- -

Between :

THE QUEEN on the application of SQ (PAKISTAN) AND ANOTHER	**Appellant**
- and -	
THE UPPER TRIBUNAL IMMIGRATION AND ASYLUM CHAMBER & ANOTHER	**Respondent**

- -

Mr Stephen Knafler QC and **Mr Mark Symes** (instructed by **Duncan Lewis Solicitors**) for the **Appellant**
Ms Kerry Bretherton (instructed by **Treasury Solicitors**) for the **Respondent**

Hearing date : 18 September 2013

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Approved Judgment

Lord Justice Maurice Kay :

1. MQ, who was born on 21 October 1997, arrived in this country from Pakistan with his mother SQ on 24 June 2012. They had visitors' visas entitling them to remain for up to six months. MQ has a very serious medical condition – beta thalassaemia – for which he had been receiving treatment in Pakistan and he also requires chelation therapy. There is no doubt that the healthcare available to him in Pakistan is of a significantly lower quality than that which is available, and which he has enjoyed, from the National Health Service here. His health and well-being are much improved. Almost immediately after arrival, SQ applied on behalf of herself and MQ for leave to remain in this country on asylum and human rights grounds. The applications were refused by the Secretary of State and their appeals to the First-tier Tribunal (FTT) were dismissed. I need say no more about the asylum claim. The human rights claim was advanced by reference to Articles 3 and 8 of the European Convention on Human Rights and Fundamental Freedoms (ECHR). It is to the effect that to return MQ to Pakistan, as the Secretary of State seeks to do, would be to subject him to inhuman treatment or would unlawfully interfere with his right to respect for his private life. His case is that, if returned, he would probably die in his late teens or early twenties, whereas in this country he would have a much longer and better life. In other words, this is what is often referred to as a "health case" in the context of Articles 3 and 8.

2. It is well-known that the existing jurisprudence places a high hurdle in the way of applicants in health cases. The leading authorities are *D v United Kingdom* (Application 30240/96), *N v Secretary of State for the Home Department* [2005] 2 AC 296 and its Strasbourg progeny, *N v United Kingdom* (2008) 25 BHRC 258. *D* and *N* were concerned with adults who had entered this country illegally. At the heart of this appeal lies a contention that, whether looked at through the lens of Article 3 or of Article 8, these authorities do not have the same reach in the case of a child who entered this country lawfully. Further, it is contended that, in the light of *ZH (Tanzania) v Secretary of State for the Home Department* [2011] UKSC 4, MQ's claim, particularly under Article 8, has to be assessed in the context of section 55 of the Borders, Citizenship and Immigration Act 2009 and Article 3 (1) of the United Nations Convention on the Rights of the Child (CRC) which require the best interests of the child to be "a primary consideration" in this context.

These proceedings

3. Following the dismissal of the appeal by the FTT, the appellants sought permission to appeal to the Upper Tribunal (UT) but this was refused, ultimately by the UT on 17 January 2013. The appellants then applied to the Administrative Court for permission to seek judicial review of the UT's refusal. On 19 April 2013, Cox J refused permission on the papers. In these circumstances, there is no right to renew the application at an oral hearing in the Administrative Court. The appellants then applied to this Court for permission to appeal against the decision of Cox J. Permission was granted by Sir Stanley Burnton on 17 July 2013. In his written reasons he said:

> "I am concerned as to whether the FTT adequately considered the medical evidence relating to MQ or gave adequate reasons for its finding that there were no countervailing factors militating against his removal. The appeal would address the

> issue as to the conflicting interests of immigration control and the interests of a sick child in a case in which the interests of the child are a paramount consideration. This is an important point of principle and given the possible consequences for this child there is also a compelling reason for permission to appeal."

I infer from the reference to "countervailing factors" and "conflicting interests" that it was the qualified right in Article 8 of the ECHR that was at the forefront of his mind rather than the absolute right enshrined in Article 3.

4. I shall have to delve into the facts and the decision of the FTT in more detail but it is appropriate to refer first to the authorities which the FTT and Cox J considered to be insurmountable barriers in the way of the appellants' case.

The authorities

5. In *D v United Kingdom*, which preceded the enactment of the Human Rights Act 1998, the Strasbourg Court was concerned with a man who had been arrested when he arrived in this country without leave to enter. He had a large quantity of cocaine in his possession. He was charged, prosecuted and convicted. Whilst in prison he was diagnosed as having HIV/AIDS. Immediately before his release from his prison sentence, the Secretary of State gave directions for his removal to his home country, St Kitts. The Court held that his removal to St Kitts would be a violation of Article 3 because he was "in the advanced stages of a terminal and incurable illness" (paragraph 51); and the abrupt withdrawal of the healthcare and support he was receiving in this country would entail "the most dramatic consequences for him" in that "removal will hasten his death" (paragraph 52). It concluded:

> "53. In view of these exceptional circumstances and bearing in mind the critical stage now reached in the applicant's fatal illness, the implementation of the decision to remove him to St Kitts would amount to inhuman treatment … in violation of Article 3 … his removal would expose him to a real risk of dying under the most distressing circumstances and would thus amount to inhuman treatment …
>
> 54. … in the very exceptional circumstances of this case and given the compelling humanitarian considerations at stake, … the implementation of the decision to remove the applicant would be a violation of Article 3."

Thus, there was a clear emphasis on the "exceptional" or "very exceptional" circumstances, which gave birth to a test of exceptionality. The Court further considered that, having regard to its finding in relation to Article 3, "Article 8 raises no separate issue" (paragraph 64).

6. The test of exceptionality was applied by the House of Lords in *N*, which concerned an illegal entrant from Uganda who was diagnosed as HIV-positive (of which she had

been previously unaware) a few days after her arrival. She was also found to have an AIDS-defining illness. Although her Article 3 claim was initially successful before an adjudicator, it ultimately failed, even though she had been receiving treatment in the United Kingdom which had resulted in a drastic improvement in her medical condition and withdrawal of that treatment would shorten her life expectancy because it would not be replicated in Uganda. Her case was seen as no different from that of those who arrived in the United Kingdom from countries where medical treatment for AIDS was not available or not of the standard freely available in this country. It did not meet the exceptionality test.

7. When *N* came to be considered in Strasbourg, that Court also concluded that the Article 3 claim failed. The judgment of the majority included these passages:

> "42. Aliens who are subject to expulsion cannot in principle claim 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 art 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 art 3, but only in a very exceptional case, where the humanitarian grounds against the removal are compelling. In *D v United Kingdom* … 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.
>
> ….
>
> 44. … art 3 does not place an obligation on the contracting state to alleviate such disparities [in the availability of treatment] 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.
>
> …
>
> 53. The court does not consider that any separate issue arises under art 8… It is not necessary, therefore, to examine this complaint."

8. A minority of three judges dissented, considering that the case was indistinguishable from *D*. The minority also considered that the case required consideration under Article 8 but proceeded to find that, although removal to Uganda would interfere with his private life, such removal would be proportionate. It seems that, in the sixteen years since *D* the only case in Strasbourg in which a health case has had a positive outcome was *BB v France* (47/1998/950/1165) but there the outcome was by way of concession rather than adjudication.

The medical evidence in present case

9. Apart from a psychiatric report (to which I shall not need to refer), the medical evidence in MQ's case came from two sources. Dr Farukah Shah is a consultant haematologist at the Whittington Hospital. She is MQ's treating clinician. She provided two letters but did not give oral evidence. Dr Bashir Qureshi is a general practitioner of long experience having practised for four years in Pakistan and, more recently, 48 years in London. He has a particular interest in transcultural medicine. He provided a lengthy report with appendices and gave oral evidence.

10. Dr Shah's first and longer letter is dated 30 July 2012. It gives her diagnosis as (1) Beta thalassaemia major; (2) severe iron overload; (3) severe growth retardation. She states that MQ requires blood transfusions at two to three weekly intervals "in order to maintain life". She adds that "without appropriate blood transfusion, [he] would die from severe anaemia and the associated heart failure that would occur as a consequence". The letter continues:

> "The mainstay of treatment for patients with Beta thalassaemia major is blood transfusion therapy in order to maintain an adequate haemoglobin to allow growth and development to occur. Blood transfusion therapy results in the development of iron overload, and the iron overload is associated with potentially fatal complications, in particular heart failure due to deposition of iron in the heart, liver cirrosis due to iron deposition in the liver, followed by fibrosis and then ultimately cirrosis, endcrinopathies, in particular diabetes mellitus, hypogonado-hypogonadism, hypothyroidism and hypoparothysoma. Essentially, the iron deposition moves to the other essential endocrine organs such as the pituitary gland, the thyroid gland and causes harm in those organs. Once a certain iron threshold is acceded … iron can be deposited in the heart. Iron deposits in the heart can cause fatal complications in particular abnormal cardiac heart rhythms, the commonest being atrial fibrillation or superventricular thakicardias, and then going on to heart failure and a dilated left ventricle.
>
> Prior to the advent of appropriate chelation therapy associated with rigorous monitoring, patients used to die of heart failure or liver cirrosis, in their late teens or early twenties. In the UK with appropriate chelation and monitoring by the year 2000, data showed that 50% of British thalassaemic patients would have died by the age of 35 years, a large proportion of these being older thalassaemic patients who had received inadequate

> iron chelation at a young age. More recent data that has been published shows that survival is extremely good in well-treated and well-managed beta thalassaemia patients, and in the UK we can now confidently say that for a well-managed thalassaemia patient, life expectancy is essentially nearly normal with a good quality of life.
>
> The current situation in Pakistan is very much like the situation that the UK was in the 1960's. With inadequate transfusion and inadequate chelation, prognosis is extremely poor with very few patients with beta thalassaemia major surviving into their thirties, the majority dying from iron-related complications in their late teens and early twenties."

11. Dr Shah describes two visits to Pakistan as an expert in thalassaemia. She states that in the area of Pakistan from which MQ has come access to blood transfusion is extremely difficult. A patient's family is generally responsible for collecting blood donors and taking them to a blood donation centre so that their child can be transfused. She opines that if he were to return to Pakistan, MQ would continue to be at high risk of receiving blood donations from infected donors and would therefore be at risk of developing HIV or hepatitis C as a consequence of his life-saving blood transfusion. As to iron chelation therapy, she states that MQ has had very restricted access to iron chelation therapy, with inadequate support being provided medically as regards dosing, frequency, duration and amount of medication. His iron burden is "so high that it cannot be accurately quantified". The letter concludes:

> "The lack of adequate chelation therapy in Pakistan has resulted in very serious endocrine problems for MQ, which are going to be impacting on his ability to grow. Should he be returned to Pakistan, his prognosis is extremely poor and he would in all likelihood die by the time he is in his late teens or early twenties, from iron associated cardiac failure or liver cirrohsis. If he was sent back to Pakistan, we would not expect him to chelate effectively due to the problems with getting adequate chelation therapy in Pakistan. We would not expect him to grow or transition through puberty, again due to the difficulties of getting growth hormone therapy, testosterone therapy and appropriate monitoring of these treatments in Pakistan.
>
> Were MQ to remain in the UK, I would envisage that with a concerted multi-disciplinary effort, this young gentleman could be effectively di-ironed over the next three to five years and we would expect him to be able to grow to a more acceptable height, and at the very least transition through puberty with appropriate multi-disciplinary support.
>
> His prognosis if he was to remain in the UK would be good, as we would be able to effectively monitor and manage his treatment, to ensure that the complications that he has already developed, did not progress or worsen."

12. Dr Shah's second letter, dated 12 November 2012, is essentially supplementary. It reveals that MQ has hypogonadothropic hypogonadism, which was confirmed by very low levels of pituitary hormones. He also has an immeasurable testosterone level and a low value of growth hormone. It describes his current treatment, adding that in general such treatment requires two years to complete but can take longer if there are other complications. It concludes:

> "Although this treatment may be available in Pakistan I doubt the expertise would be available to take MQ through the treatment and successfully give him an acceptable height."

13. Dr Qureshi's report was concerned with the availability of treatments in Pakistan. As he gave oral evidence, it is more appropriate to advert to his opinions by reference to the findings of the judge in the FTT.

The decision of the FTT

14. The judgment of the FTT is that of Judge Kanagaratnam. Its first concern was with the asylum appeal which turned out to be without merit. It seems that the health case, by reference to Article 3 and Article 8, was put primarily on the basis that, if returned to Pakistan, MQ would have to receive blood transfusions "which are not sufficiently screened … exposing him to risks such as hepatitis B and C or HIV". It was the additional risk arising from that which was said to expose his life to danger. The judge's conclusions commenced with the following passage:

> "In this instance the appellant's rights under Article 3, bearing in mind that he is a child, would have to be considered. In doing so I have taken into consideration the objective material relating to Pakistan in the country information report together with Dr Qureshi's evidence, the letter from the Whittington Health Authority and the psychiatric report …"

15. There is then set out some of the country information relating to the number and distributions of health care providers, with references to problems of affordability of health care. Reference was specifically made to the evidence of Dr Qureshi who had stated, among other things, that "the screening facilities for blood transfusion and treatment for chelation is available in Pakistan, if one can afford it". The judge noted that "a letter from the Whittington Health Authority … does not speak of any life-threatening condition". He concluded:

> "For these reasons on the entirety of the evidence before me I do not find that the appellant's life is endangered so as to accede the threshold set out in the case of *N* even if the appellant was impecunious. The appellant would therefore immutably be able to relocate in Pakistan if required however unpalatable the prospect may be. Considering the question of private life which has been raised the appellant has been in the United Kingdom for a brief period and the treatment he receives is a good part of the private life of the appellant's life here and has been settled in the above paragraph. For these reasons I do not find that the private life of these appellants

> would be infringed upon their removal to Pakistan. Considering the question of the best interests of the child I have been asked to consider the position in *ZH (Tanzania)* and find that the appellant's cultural, linguistic and family ties are best maintained in his country of origin. I have also noted that there are no countervailing factors that militate against the removal of this appellant in the context of Article 8 and section 55."

He therefore dismissed the appeal on all grounds. As I have related, permission to appeal to the UT was refused by the UT and an application for permission to apply for judicial review was refused by Cox J.

This appeal

16. I have referred to the terms in which Sir Stanley Burnton granted permission to appeal. The grounds of appeal are wide ranging but can be summarised as follows. (1) The FTT had no or insufficient regard to the fact that MQ is a child. This fact is said to have significance in relation to both the Article 3 and Article 8 claims, albeit that the emphasis is now placed more squarely on Article 8. (2) Particularly in relation to Article 8, it is said that the FTT carried out a flawed exercise in relation to *ZH (Tanzania)* and section 55. (3) For this and other reasons, the approach of the FTT to Article 8 was legally flawed. The other reasons include criticisms of the way in which the FTT treated the medical evidence. It is central to the case for the appellants that both *D* and *N* concerned adults who had entered the United Kingdom unlawfully. MQ, on the other hand, entered lawfully, albeit with limited leave, and was and remains a child.

Article 3

17. Stripped of its references to torture and punishment, Article 3 provides:

> "No one shall be subjected to inhuman or degrading treatment …".

It is well known that a contracting state may infringe Article 3 if it returns a person to a country where he would be at substantial risk of inhuman or degrading treatment: see *Soering v United Kingdom* [1989] 11 EHRR 439, which provided the jurisprudential basis for *D*. However, the imposition of a "high threshold" is equally well established and this is underlined by the test of exceptionality illustrated by *D* and *N*. On the other hand, Article 3 confers an unqualified right. Ultimately the question is whether what is likely to befall the claimant crosses the high threshold and the test of exceptionality. Whether or not the required level of severity is reached in a particular case depends on all the circumstances of that case. I accept that there are circumstances in which the threshold will be reached in relation to a child where it would not be reached in the case of an adult. As Baroness Hale said in *E v Chief Constable of the Royal Ulster Constabulary* [2009] 1 AC 536 (at paragraph 9) :

> "The special vulnerability of children is also relevant to the scope of the obligation of the State to protect them from such treatment."

She referred to "the instructive case" of *Mayeka and Mitunga v Belgium* [2006] 46 EHRR 449. However, in the present case the evidence, taken at its highest, and making every allowance for the age of MQ, does not establish that the high threshold is satisfied. To put it bluntly, MQ would not be returning to an early and solitary death in Pakistan. He had been receiving treatment and blood transfusions without contracting HIV, hepatitis B or C before leaving Pakistan. He also received chelation therapy although his mother states in her witness statement that he sometimes missed that treatment for a month or two because they did not have the money to pay for the best medication and sometimes they had to use inferior alternatives. In 2010, MQ contracted malaria and typhoid but it is not established that this was the result of receiving unscreened blood transfusions.

18. In his consideration of Article 3, the judge did take account of MQ's age. The relevant passage begins "bearing in mind that he is a child". It is submitted, and I accept, that there are unimpressive features of the judge's consideration of the medical evidence, including a suspicion that he considered only one and not two letters from Dr Shah. On the other hand, the totality of Dr Qureshi's evidence, written and oral, was somewhat ambivalent and confusing.

19. There is no doubt that, on return to Pakistan, MQ would receive treatment inferior to that which he is presently receiving in this country. However, the circumstances fall significantly short of the high threshold. Some of the material relevant to this conclusion is better considered in the context of Article 8.

Article 8

20. The FTT dealt with the Article 8 claim somewhat cursorily in the final four sentences of the passage which I have set out in paragraph 10, above. Having correctly observed that the appellants had only been in this country "for a brief period" and that the treatment received by MQ was "a good part of [his] private life" here, the judge simply concluded that he did not find the "private lives of these appellants would be infringed upon their removal to Pakistan". He then referred to *ZH (Tanzania)* and the best interests of MQ but found that his "cultural, linguistic and family ties are best maintained in his country of origin", noting that "there are no countervailing factors that militate against the removal of [MQ] in the context of Article 8 and section 55". It is impossible to escape the conclusion that the Judge never considered MQ's medical conditions and treatment in the context of his best interests.

21. *ZH (Tanzania)* demonstrates the central role of the best interests of a child in an Article 8 case. The archaeology is as follows. International treaty obligations, in particular Article 3(1) of the CRC have developed a consistent theme. Article 3(1) provides:

> "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."

22. Section 11 of the Children Act 2004 obliges a wide range of public bodies to carry out their functions having regard to the need to safeguard and promote the welfare of children. Initially, the immigration authorities were excused from this obligation

because this country had entered a general reservation to the Convention in relation to immigration matters. However, things changed with the enactment of section 55 in 2009. It requires that, in relation to immigration, asylum and nationality, the Secretary of State must make arrangements for ensuring that those functions

> "are discharged having regard to the need to safeguard and promote the welfare of children who are in the United Kingdom."

The wide significance of this was explained by Baroness Hale in paragraph 24 of her judgment in *ZH*:

> "This means that any decision which is taken without regard to the need to safeguard and promote the welfare of any children involved will not be 'in accordance with the law' for the purpose of Article 8(2). Both the Secretary of State and the tribunal will therefore have to address this in their decisions."

To require that the best interests of the child are "a primary consideration" does not mean that those interests must always prevail. As Baroness Hale went on to say (at paragraph 33):

> "In making the proportionality assessment under Article 8, the best interests of the child must be a primary consideration. This means that they must be considered first. They can, of course, be outweighed by the cumulative effect of other considerations. In this case, the countervailing considerations were the need to maintain firm and fair immigration control, coupled with the mother's appalling immigration history and the precariousness of her position when family life was created. But, as the Tribunal rightly pointed out, the children were not to be blamed for that."

23. The appeal succeeded in *ZH* because, as Lord Hope put it (at paragraph 42), "the best interests of the children melted away in the background" of the Tribunal's consideration.

24. In my judgment, the consideration of Article 8 by the FTT in the present case was similarly flawed. It was incumbent upon the Judge to identify <u>all</u> features of MQ's private life which would be subjected to interference upon his removal. These were headed by the discontinuation of the treatment he is receiving in this country. It seems to me that the issue of interference admits of only one answer here and the FTT erred in coming to the contrary conclusion. The real issue is proportionality. Unfortunately, the FTT seems to have excluded health considerations and the discontinuation of the UK treatment from its *ZH* assessment. That was a material error of law.

25. On behalf of the Secretary of State, Ms Kerry Bretherton submits that, even if the FTT fell into legal error (which she does not concede), this is an "only one answer" case. Accordingly, we should dismiss the appeal. I disagree. In my judgment, the legal errors were such that the appropriate course is for us to part company with Cox

J, to grant permission to apply for judicial review, to deal with the matter substantively and to remit the case to the UT for it to determine the appeal. It is the expert tribunal for the carrying out of a proportionality assessment such as is now required.

26. What this case demonstrates is that in some cases, particularly but not only in relation to children, Article 8 may raise issues separate from Article 3. In *JA (Ivory Coast) v Secretary of State for the Home Department* [2009] EWCA Civ 1353, an adult succeeded under Article 8 (but not Article 3) in a health case. Sedley LJ emphasised (at paragraph 17) that each of the two Articles "has to be approached and applied in its own terms". The leading authorities of *D* and *N* were distinguished on the basis that, in both of them, the appellants' presence and treatment in this country "were owed entirely to unlawful entry". JA's appeal was allowed and her case remitted because of the potential significance of the fact that, following her lawful entry and subsequent diagnosis of HIV+, she had been granted further exceptional leave to remain for treatment. Although no separate Article 8 issue arose in *D* or *N*, it plainly did in *JA*.

27. I do not intend to predict or seek to influence the outcome of the present case on remittal. On the one hand, MQ can pray in aid his lawful entry and his status as a child with the protection of the *ZH* approach. On the other hand, he arrived with his serious medical conditions at an advanced stage and, although not an unlawful entrant, it will be relevant to consider whether his arrival here was a manifestation of "health tourism". If it was, that would fall to be weighed in the balance. After all, this country is under no international obligation always to act as "the hospital of the world". The difficult question is whether it would be disproportionate to remove this child in the light of all the evidence in the case, including the medical evidence which, at present, is not as clearly presented as it could be.

Conclusion

28. For all these reasons, I would allow this appeal and remit the case to the UT for rehearing. In all the circumstances, I consider that the appellants should remain anonymised.

Lord Justice Lewison:

29. I agree.

Lord Justice Underhill:

30. I also agree.