Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Numbers: HU/07321/2017
HU/07322/2017
HU/07324/2017

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
On 7th May 2019	**On 28th June 2019**

Before

UPPER TRIBUNAL JUDGE BRUCE

Between

HK
GC
RC
(anonymity direction made)

Appellants

And

Secretary of State for the Home Department

Respondent

For the Appellants: **Ms M. Malhotra, Counsel instructed by RW Anderson**
For the Respondent: **Mr N. Bramble, Senior Home Office Presenting Officer**

DECISION AND REASONS

1. The Appellants are all nationals of Pakistan. They are respectively a mother, father and their minor daughter, born in 2010. Their linked human rights appeals were dismissed by the First-tier Tribunal (Judge

Garbett) on the 20th March 2018. They were granted permission to appeal against that decision on the 22nd June 2018 by First-tier Tribunal Judge Haria.

2. The Appellants seek leave to remain in the United Kingdom on human rights grounds. The basis of their claim is that the youngest Appellant, R, is suffering from a medical condition for which she would not receive treatment or adequate care in Pakistan. It is submitted that this lack of provision will result in serious consequences for R: she will be denied an education, could face a rapid and irreversible decline in her health and in the worst-case scenario could die. The illness is Type I diabetes mellitus. The family rely on Articles 3 & 8 of the European Convention on Human Rights (ECHR).

The Decision of the First-tier Tribunal

3. The First-tier Tribunal found that the Appellants entered the United Kingdom with leave as Tier 4 Migrants in August 2014, and that this leave continues today by virtue of s3C of the Immigration Act 1971. R was diagnosed in May 2015. The Tribunal accepted as credible all of the evidence it heard from the adult Appellants. The medical evidence in respect of R was unchallenged. The only factual issue between the parties was the availability of care and associated support in Pakistan for R's condition. The Tribunal noted that R's parents had gone to some effort to research what care might be available. This had included evidence from the first Appellant about an acquaintance of hers whose daughter N also suffered from Type I. The doctors treating N in Pakistan had used techniques that were over 50 years old; her condition deteriorated and she had died. The first Appellant's evidence about N was supported by the 'death notes' of her doctor and sworn affidavits from N's parents who set out in more detail what had happened to their daughter. The Appellants had also provided various articles and blogs. The Respondent had produced no country background material on the point.

4. The Tribunal found [at §25] that the treatment for diabetes in Pakistan is more limited than in the United Kingdom; in 2016 the WHO reported that insulin is not widely available, although Metformin and Sulphonylurea are. The Tribunal took judicial notice of the fact that these are drugs used to treat Type II rather than Type I diabetes. Blood glucose measurements are not generally available in primary care settings. The determination then says this:

> "The fact that they are not "generally available" does not however mean that they are not available at all. I also note that this information is now two years old and the position may have moved

> on. In oral evidence the first Appellant confirmed that insulin is available privately and that a doctor in a hospital in Lahore specialises in the treatment of Type I diabetes albeit that her techniques and treatment are not as advanced as those [R] currently receives".

5. As to the efficacy of such treatments, and their utility for R, the Tribunal drew a distinction between her position and that of N and her parents [still at §25]:

> "In conclusion, I accept that there is a general national unawareness of type I diabetes in Pakistan. I also accept that there is limited availability of insulin, as well as blood sugar testing. However, there is some availability in these Appellants have the advantage, if I can put it that way, of knowing that [R] suffers from this difficult condition which I find distinguishes them from the tragic positions that [N] and her family faced as well…"

6. The Tribunal noted that both of the adult Appellants are educated professionals and that they would be able to work in order to pay privately for treatment. They both speak the language and spent approximately 30 years of their lives in that country. There would be disruption to their lives but upon return to Pakistan they would have the support of family. As to R's education the Tribunal accepted that because of the general lack of awareness of Type I diabetes in Pakistan schools there would not provide the same level of care and support that R currently receives here.

7. Applying these facts as found within the legal framework the Tribunal found, in respect of Article 8:

   i) That Article 8 was engaged because there would be an interference with the family's private life here [§35];

   ii) It would be in the best interests of R to remain in this country [§36];

   iii) The public interest considerations at 117B of the Nationality, Immigration and Asylum Act 2002 must weigh against the Appellants [§37];

   iv) Although the family were unaware of R's condition on arrival (and so cannot be deemed 'health tourists') they have not been granted leave to remain on health grounds and so the United Kingdom cannot be said to have taken responsibility for R's care;

   v) Weighing these factors in the balance the decision is not disproportionate.

8. In respect of Article 3 the Tribunal directs itself to the high threshold imposed in N v United Kingdom (Application no. 26565/05) (2008) 47 EHRR 39. The determination notes that the threshold to be applied in the

case of a child may be different from that of an adult. The Tribunal was not however satisfied that R's condition has reached such a critical stage that she is dying. Nor did it accept, on the evidence before it, that medical treatment in Pakistan is entirely unavailable in Pakistan such that intense suffering or death on return would be imminent.

9. The appeals were therefore dismissed on all grounds.

The Challenge

10. At a hearing on the 21st January 2019 the Appellants submitted that the decision of the First-tier Tribunal was flawed for the following errors of law:

    i) That the First-tier Tribunal's reasoning was premised on a fundamental misapprehension of the facts;

    ii) The First-tier Tribunal impermissibly speculated that the position in Pakistan may have changed, rather than relying on the actual evidence before it;

    iii) The First-tier Tribunal misdirected itself to the applicable test in N v United Kingdom (2008) 47 EHRR 39;

    iv) The Tribunal failed to apply the N Article 3 threshold having regard to the young age of the individual concerned;

    v) The decision is flawed for lack of reasons, the Tribunal failing to explain why the public interest outweighed R's best interests in this case.

11. At the 'error of law' hearing the Respondent was represented by Senior Presenting Officer Mr Diwnycz who substantially conceded that the grounds were made out, for the reasons set out below.

Discussion and Findings on 'Error of Law'

Ground (i)

12. Ground (i) is that the First-tier Tribunal made a material error of fact in respect of the child 'N'.

13. The passage cited (set out above at my §5) indicates that the Tribunal was under the impression that the cause of N's death, or at least a contributory factor, was that her family and clinicians were unaware that she was suffering from Type I diabetes, and so administered the wrong treatment. In fact, as Mr Diwnycz concedes, the evidence was that N had already

been correctly diagnosed with Type I diabetes; she died because the doctors were unaware of the correct treatment and/or it was not available.

14. Ground (i) was therefore made out by consent.

Ground (ii)

15. Ms Malhotra submitted that the Tribunal further erred in apparently discounting the actual evidence before it on the basis that "the position may have moved on" [at my §4 above]. Insofar as this indicated that the Tribunal proceeded on the basis that matters might have improved in the two years since the WHO report etc, Mr Diwnycz accepted that this too must be an error of law. Whilst he points out that the Tribunal did make findings on the actual evidence, he accepted that it was an error to base a risk assessment on speculation that things might improve in the future.

16. Ground (ii) was therefore made out by consent.

Grounds (iii) & (iv)

17. I take grounds (iii) and (iv) together because they are both concerned with how the Tribunal approached the question of Article 3 and how it might apply to R's situation.

18. At §41 of the determination the Tribunal concludes:

> "Her medical condition cannot be said to have reached such a critical stage that she is dying. I also do not accept that medical treatment is entirely unavailable in Pakistan such that intense suffering or death on return would be imminent".

19. At §42-44 the Tribunal then considers the jurisprudence to the effect that the N threshold may be lower if one is considering the impact upon a child. Having done so, and having accepted the principle, the Tribunal reiterates:

> "Her medical condition is not so grave that she can be described as dying and I do not accept that there would be an imminence of intense suffering or death on her return to Pakistan where I have found there is treatment albeit it that it is more limited".

20. The Appellant submits that these conclusions are flawed for a number of reasons.

21. First, they are vitiated by the errors already identified, in that the Tribunal apparently misunderstood the evidence. Given his concessions in respect of ground (i) and (ii) Mr Diwnycz was bound too to accept this criticism. Whilst he maintained that the conclusions reached may, in the final analysis, be open to the determining Tribunal, he accepted that in this fact-

sensitive assessment it was important that the Tribunal had an accurate understanding of what those facts actually were.

22. Second, it is submitted that the Tribunal has elevated the test in Article 3 to the bald question of whether R is currently dying, or would die upon her return to Pakistan. Even if the Judge was not minded to accept the 'modest extension' imported by the decision in Paposhvilli v Belgium (application number 41738/10) the appropriate question to ask was whether R would be exposed to inhuman and degrading treatment. In N the ECtHR put it like this:

> "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.

23. The Appellant submits that by focusing on the question of death the Tribunal impermissibly narrowed the test in N to exclude consideration of whether R would be exposed to inhuman and degrading treatment; the Tribunal did not ask itself whether, taking into account her young age, and its own finding that the family have always had leave and are not 'health tourists', whether the "humanitarian grounds against removal are compelling". Nor were clear findings made on what the likely consequences would be for R if she were returned to Pakistan.

24. I am satisfied that this ground is made out. Whether viewed through the prism of Article 8 or 3, this was an intensely fact-sensitive case. Nowhere in the reasoning does the Tribunal appear to consider what the actual consequences of removal would be for R. The fact that "some" treatment is available in Pakistan, or the fact that her parents could pay for it, was of little consequence to R if it was not the correct treatment, as the tragic case of child N illustrated. The evidence indicated that R is currently the recipient of a "complex" diabetes management plan. Her parents, specialist nurses and teachers are checking her blood sugar levels regularly throughout the day, counting her carbohydrates and

administering a particular kind of insulin that is only rarely available in Pakistan. As the determination records [at for instance §6 and 13], it was the clear evidence of the clinicians that without this complex management plan, and the particular form of insulin she requires, this child could die. Jane Humphries, the Lead Paediatric Diabetes Specialist Nurse at Queen's Hospital, Burton-on-Trent explains that some of the consequences of a failure in management would include musculoskeletal complications, cardiovascular disease, retinopathy and neuropathy. The evidence concerning Pakistan before the Tribunal was not simply concerned with the availability of R's particular form of insulin, the focus of §42-44 of the Tribunal's conclusion, but with the absence of treatment for these attendant conditions. The evidence also appeared to indicate that the "basic technologies" required as part of this complex management plan – i.e. various testing kits, pumps etc- were not generally available in Pakistan [see §17(i)]. I can find in the decision no analysis of what the consequences would be for R if she were not able to access these technologies, nor of what the impact would be for her if her management plan broke down, for instance because of a lack of glucose testing. Although the Tribunal has properly directed itself to the authorities, for instance SQ (Pakistan), it is difficult to see that it has applied the principles therein.

Ground (v)

25. It perhaps follows from what I have said that the final ground must also be made out. If the Tribunal failed to make fact-specific findings on what the actual consequences would be for R of return to Pakistan, it must follow that the proportionality balancing exercise must also be set aside.

The Re-Made Decision

26. At a 'continuance' hearing on the 7th May 2019 I heard submissions on behalf of both parties. The Appellants' continue to be represented by Ms Malhotra. On this occasion the Respondent was represented by Mr Bramble, Senior Presenting Officer. Both parties submitted, with leave, further documentary evidence.

The Evidence

27. The Appellants rely upon what is described as a 'Best Interests Report' dated the 4th April 2019 by Independent Social Worker Lynn Coates. To prepare her report Ms Coates reviewed documents including the Home Office papers, R's school reports, character references and medical evidence; she further interviewed each member of the family, observed R

in the home and interviewed R's aunt, and Mrs Tranter, R's primary school SENDCO. The salient points to be drawn from the report are these:

- Ms Coates observed the family speaking English with each other, supporting the family's contention that R does not speak, read or write Urdu
- R wears western clothes and speaks with a Staffordshire accent. Ms Tranter told Ms Coates that she believes that R would regard herself as British; to her knowledge she has no experience of Pakistani culture or traditional Muslim practices
- R left Pakistan at the age of four and told Ms Coates that she has no real memory of the country
- R's aunt, who formerly taught at a private school in Pakistan, expressed two concerns about R entering the school system there. First, she was doubtful about whether staff would have the training or understanding of how to deal with R's condition. Second, in her experience children with such conditions are frequently bullied by peers in Pakistani schools
- R is currently cared for by the Paediatric Diabetic Team at Queen's Hospital
- As part of that care R is receiving monthly CBT and counselling sessions, the focus of which is to help her with her "anxieties regarding her diagnosis and to assist her in coming to terms with having a chronic life-long condition"
- R told Ms Coates that she has a lot of friends, both at school and in her local community. R told her "I trust my friends and my teachers they look out for me and make sure that if I need help I get it, they are kind to me"
- Ms Tranter told Ms Coates that "four members of staff are trained to deal with [R]'s diabetes, checking her blood sugar levels three times per day and administering insulin when needed". Ms Tranter explained to Ms Coates that this monitoring is "essential to ensure that [R] is well and safe during the school day"

28. In reaching these findings Ms Coates has drawn on a wide range of sources including those independent of the family such as the medical records and the "detailed" conversation with Ms Tranter. I am therefore prepared to place a good deal of weight on these conclusions. I place no weight on the remainder of the report, in which Ms Coates opines on matters such as the education system in Pakistan, and the availability of healthcare there. Whilst I appreciate that Ms Coates has drawn upon external sources in order to offer this evidence, I am unable to give her

conclusions any weight in my deliberations since she is not, as far as I have been made aware, an expert witness.

29. I was further provided with a letter directly from Ms Tranter who confirmed that whilst she is at school R requires a "substantial amount of care". Her blood sugar levels are checked regularly by staff who administer insulin where necessary. This is routinely completed twice per day, but more often if R is feeling unwell or during exercise. The staff receive specialist training once per year and have been assessed to ensure that they are competent in administering the insulin and taking the blood sugar readings. R's carbohydrate intake is weighed by two members of staff according to her blood sugars. The staff at the school maintain regular communication with R's diabetes treatment team and her parents. A letter dated 8th February 2018 from Alyson Church, Assistant Head at R's primary school confirms much of what is said by Ms Tranter, stressing that staff receive regular specialised training in how to manage R's condition. I note that there is a slight discrepancy in the evidence in that Ms Tranter apparently told Ms Coates that there are four staff members who are so trained, whereas Ms Church states it to be six – I am not satisfied that anything turns on that. It may simply be that four are expected to be on site, but as Ms Church states, there are six who receive the training "so that we can cover absences". The point consistently made is clear – that the school has taken its duty of care towards R very seriously and has ensured that there are a number of members of staff who are able to monitor and manage her condition, including weighing her food, measuring her blood glucose etc, administering insulin and if necessary taking the appropriate action to manage a hypo.

30. In respect of the medical evidence it is of course not in issue that R does suffer from Type 1 diabetes. Nor is it disputed that the very many letters, appointment cards and reports from clinicians in the bundle confirm that R is being regularly monitored and treated. I therefore invited submissions simply on what the consequences would be for R if there were to be any interruption in care or deviation from in her current treatment plan.

31. Ms Malhotra began by taking me to the 'discharge slip' issued by Burton Hospital NHS Foundation Trust in May 2015. This shows that R was admitted to 'resus' on the 10th May acutely unwell: she was pale, had mottled skin and was having difficulty breathing. Staff initially suspected sepsis but within a day, made the diagnosis of diabetes. A more detailed discharge summary sent by the hospital to R's GP on the 13th May states that upon admission she was "semi-conscious, peripherally shut down and extremely dehydrated". Ms Malhotra invited me to find that absent the treatment she is currently receiving, R would once again face admission to 'resus' for these, or similar, conditions. This submission would appear to be supported by a further letter sent by Dr Jacob Samuel

on the 20th January 2016. Dr Jacob explains that at that stage doctors were struggling to maintain steady blood sugars for R. She was being tested at least five times per day and being given two different forms of insulin, Novo Rapid and Glargine. Dr Jacobs explains that because R is a child, her care needs are complex. She needs to be monitored closely in order to avoid complications such as kidney and eye problems. He writes:

> "Type 1 diabetes is a lifelong condition and unless it is looked after properly, there is a chance that she will develop complications at a very young age and will need regular input from the specialist clinics and specialist nurse, which we are currently providing.
>
> If she does not receive regular medical support her condition will deteriorate and cause serious risk to her health. Her parents are trying their best by working with us in this respect"

32. More baldly Paediatric Diabetes Specialist Nurse Jane Humphries, in her letter of the 20 May 2015, writes:

> "Type 1 diabetes is where the pancreas is unable to make insulin. Without insulin, we would die as the body is unable to change glucose (sugar) into the energy that is needed to live. To compensate for the lack of natural insulin injections of insulin are required.
>
> With the help of trained adults, we can manage diabetes in children at home and school. We need to teach people how to test blood glucose levels and what to do when the levels are out of acceptable limits. We also need to teach them how to count carbohydrates in the food eaten so they can then calculate the amount of insulin that is required. We then need to teach how to inject the insulin dose that has been calculated"

33. Nurse Humphries has reiterated these points more recently in her letter of the 20th February 2018:

> "If not managed correctly diabetes is life threatening and can lead to an average of a 15-20 year shorter lifespan and a multitude of long term microvascular complications, including cardiovascular disease, retinopathy, nephropathy and neuropathy. These complications can be seen in young people if diabetes control has not been optimum in their early years. To maintain good diabetes control there is a need for regular access to specialist diabetes services. Type 1 sufferers are dependent on insulin injections – without which they would die as they did pre-discovery of insulin in the 1920s. If diabetes is not managed correctly they risk having high blood glucose levels and ketones (which are the end products of fat metabolism). This is turn can progress to diabetic ketoacidosis (DKA) which is the biggest cause of death in young people with diabetes…

> [R] is still a very young child who not only is still in the 'honeymoon phase' but is also growing and secreting various hormones that block the action of insulin – this in turn leads to fluctuating and inconsistent blood sugar levels"

34. I was finally referred to a 'checklist' given to parents of children diagnosed with diabetes of what they need to take home and remember. R's list states that she needs two types of insulin, the Novo Rapid and Glargine. The spare doses need to be stored in the fridge and the 'pens' used to administer it need to be stored at room temperature. She requires two different types of blood test strips: one for blood glucose to be used pre-meal and pre-bed, and one for blood ketones to be used if blood glucose shows a reading of over 14 mmols. She needs four different items in order to treat hypoglycaemia, including a glucogen injection kit which again must be stored in a fridge. She must in addition keep at home a box of spare insulin pen needles (a fresh needle must be used in each injection), a sharps box, 2 insulin pens, 2 meters, 2 medicine measures, daily food/glucose sheets, a diary and emergency contact numbers of the specialist team.

35. The evidence on Pakistan that was before the First-tier Tribunal is set out at paragraph 17 of Judge Garbett's decision:

> "(i) I have an extract from the World Health Organisation - Diabetes Country Profiles, 2016-Pakistan (Appellants' bundle page 29). This reports that in Pakistan in terms of "policies, guidelines and monitoring" there is no operational policy/strategy/action plan for diabetes, to reduce overweight and obesity or to reduce physical inactivity; no evidence based national diabetes guidelines/protocols/standards were available; no standard criteria for the referral of patients from primary care to higher level of care were available and there is no diabetes registry or recent national risk factor survey in which blood glucose was measured. In terms of the availability of medicines in the public health sector Metformin and Sulphonylurea are generally available. However insulin is not generally available. In terms of procedures, retinal photocoagulation, retinal replacement therapy by dialysis and retinal replacement therapy by transplantation are not generally available. In terms of basic technologies in primary care facilities blood glucose measurement, oral glucose tolerance test, HbA1c test, dilating fundus examination, foot vibration perception by tuning fork, foot vascular status by Doppler and urine strips for glucose and ketones measurement are not generally available.
>
> (ii) I also have a blog entry published on 2 September 2016 "who is to blame for negligence towards patients at military hospitals". This reports that there is a lack of treatment and support for insulin-dependent diabetics in Pakistan.

(iii) I have an undated report from "Global Diabetes Scorecard" in relation to Pakistan. This reports;

> *"Pakistan is beginning to take action to respond to the challenge of diabetes but progress needs to be made on a national plan and preventative policies, as well as monitoring and surveillance. The Member Association reports that diabetes and NCD services are insufficient due to budget restraints and inadequate distribution of funding.*
>
> *The low level of diabetes -related health expenditures has prevented a very small proportion (0.4%) of diabetes related deaths. Increased funding for cost-effective diabetes prevention and treatment is needed."*

(iv) I have "highlighted news with links" summarising extracts from various press reports relevant to diabetes in Pakistan;

(v) I have a letter from the Punjab Education Foundation dated 25 January 2016 which records;

> *"It is stated that in Pakistan there are no medical facilities for the regular/emergency treatment of type I diabetes in schools. It is further stated that schools in Pakistan are facing lack of training regarding type I diabetes due to insufficient provisions in this regard. In addition parents often hesitate to share their child's medical condition due to the social stigma attached to this condition and leads to bullying in schools and society as a whole. This situation leads both parents and child depressed/stressed asking for the need of mass awareness campaigns for this growing medical condition."*

36. I would add that item (iv) of Judge Garbett's summary is a summary of online news stories (with hyperlinks) which I believe has been collated by R's parents. The following points are to be gleaned from these articles:

i) That there are "very few" private institutions in Pakistan which can provide services for children with special needs, and no provision at all in the public sector (The Nation, 8th June 2016);

ii) Hot weather can increase the risk of hypoglycemia and heat exhaustion for diabetics. Hypos may also be harder to spot in hot weather (www.diabetes.co.uk);

iii) Pakistan's Interior Minister admits that between 45-50% of drugs sold in Pakistan are either fake or of substandard quality. The Pakistani Pharmacist Association reports that there are 4000 licensed pharmacies, but over 100,000 illegal merchants selling medications purporting to be genuine (CNN, 30th August 2015);

iv) Due to a lack of awareness and training by adult staff, school pupils with diabetes can be denied emergency treatment; social stigma remains a serious problem, with a strong belief that girls with Type 1 would be a financial burden on a family, and would be unable to

conceive (Indian Journal of Endocrinology and Metabolism, Sept/Oct 2014)

37. Before me the Respondent relied on the updated Country Policy and Information Note *Pakistan: Medical and Healthcare Issues*, published in August 2018. Under the heading 'diabetes' the CPIN reproduces a report from the Gulf News in June 2017 stating that a UAE-based Pakistani doctor was undertaking an ambitious project to build the first ever diabetes hospital for underprivileged patients in Pakistan. This will be built in Islamabad and will create awareness as well as providing treatment. The foundation established by this doctor is now the biggest charity in Pakistan, and even before the facility is built it has managed to treat 45,000 people from a temporary facility. The MedCOI website is also cited as stating that certain tests for blood sugar levels are available and that "insulin and insulin injection devices were available" [3.1.2]. It was not clear from this document to what extent Type 1 diabetes may be treated, nor whether the type of insulin referred to in the MedCOI report were the types of insulin required by R.

Discussion and Findings

38. I begin by recording, and accepting, a submission made by Mr Bramble in respect of the interplay between Articles 3 and 8 in the context of health care cases. Mr Bramble quite properly pointed out that the tests are here "in close alignment": GS (India) v Secretary of State for the Home Department [2015] EWCA Civ 40, AM (Zimbabwe) v Secretary of State for the Home Department [2018] EWCA Civ 64. If a medical claim fails under Article 3, it is unlikely to succeed under Article 8 unless there is some additional factual element to bring the claim within the Article 8 paradigm, such as the capacity to form and enjoy relationships. This principle is, observed Laws LJ in GS (India), consistent with the Court's findings in MM (Zimbabwe) v Secretary of State for the Home Department [2012] EWCA Civ 279. The fact that an individual receives life saving treatment in this country, or may be unable to access it in the country to which he will be removed, are neither factors which could *in themselves* be determinative of an Article 8 claim, although they may of course be factors relevant to the overall balancing exercise.

39. The starting point for consideration of Article 8 in any case such as this, where no member of the family enjoys settled status in the United Kingdom, is paragraph 276ADE(1):

> **276ADE(1)**. The requirements to be met by an applicant for leave to remain on the grounds of private life in the UK are that at the date of application, the applicant:

> (i) does not fall for refusal under any of the grounds in Section S-LTR 1.1 to S-LTR 2.2. and S-LTR.3.1. to S-LTR.4.5. in Appendix FM; and
>
> (ii) has made a valid application for leave to remain on the grounds of private life in the UK; and
>
> (iii) has lived continuously in the UK for at least 20 years (discounting any period of imprisonment); or
>
> (iv) is under the age of 18 years and has lived continuously in the UK for at least 7 years (discounting any period of imprisonment) and it would not be reasonable to expect the applicant to leave the UK; or
>
> (v) is aged 18 years or above and under 25 years and has spent at least half of his life living continuously in the UK (discounting any period of imprisonment); or
>
> (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.

40. It is accepted that R can place no reliance on any of the alternate paragraphs in that provision since none can apply to her: although she is under the age of 18 she has not lived continuously in the United Kingdom for at least 7 years (she only arrived in 2014). All of the other provisions can be applied only to adults. The two adults in this case cannot rely on (iii), because they have not established such long residence, nor by virtue of their respective ages, can either of them rely on (v). The only provision of 276ADE(1) that might potentially apply to R's parents is (vi), which would require them to show that there were "very significant obstacles" to their integration in Pakistan. Before me Mr Bramble accepted, as a matter of principle, that difficulties faced by R could amount to difficulties – or obstacles – for her parents. I therefore assess the nature of such obstacles as they are faced by the family as a whole.

41. In Kamara v Secretary of State for the Home Department [2016] EWCA Civ 813 the Court of Appeal emphasised that the test of "very significant obstacles" derives from the jurisprudence on private life claims in removal cases. Whilst practical obstacles such as accommodation and finances *may* be relevant to this assessment, the focus of enquiry should be on the ability of the individual concerned to enjoy a meaningful private life in the country of return. The question would therefore be whether he or she would be able:

> "… to operate on a day-to-day basis in that society and to build up within a reasonable time a variety of human relationships to give substance to the individual's private or family life".

42. This guidance is consistent with how the Secretary of State interprets the rule. In his policy guidance *Appendix FM 1.0 Family Life (as a Partner or Parent) and Private Life: 10-Year Routes* January 2019, the Respondent instructs caseworkers that the starting point should be the presumption that integration will be possible. It is for the applicant to introduce evidence to demonstrate that it is not. A number of factors can be considered, for instance linguistic, familial, cultural and social ties to the destination country, but the focus should, in the Respondent's view, be on the extent to which it is possible for the applicant to enjoy an Article 8 private life if removed from the United Kingdom:

> 'A very significant obstacle to integration means something which would **prevent or seriously inhibit the applicant from integrating into the country of return**. The decision maker is looking for more than obstacles. They are looking to see whether there are "very significant" obstacles, which is a high threshold. **Very significant obstacles will exist where the applicant demonstrates that they would be unable to establish a private life in the country of return, or where establishing a private life in the country of return would entail very serious hardship for the applicant**.'
>
> (emphasis added)

43. The Court of Appeal judgment in Kamara, and the Secretary of State's policy guidance, are both in turn consonant with the jurisprudence of the European Court of Human Rights, which has consistently held that the term 'private life' encompasses "the physical and moral integrity of the person"[1] and that this must include, fundamentally, the right to establish and develop relationships with other human beings: see for instance McFeeley v United Kingdom[2] and Pretty v United Kingdom[3]. It is for that reason that the rule will also inform my decision 'outside of the rules'. As both parties accepted, the only real difference between 276ADE(1)(vi) and the proportionality balancing exercise in a freestanding *Razgar* assessment would be that in respect of the latter I would be bound to weigh in the balance the quality and depth of the Appellants' individual private lives in this country, a factor specifically excluded under the rule.

44. What then of the facts?

[1] See for instance X and Y v The Netherlands (A91 para 29)
[2] No 8317/78, 20 DR 44 at 91
[3] (2002) 35 EHRR 1

45. I note that both of the adult Appellants express concern that they would face financial and practical difficulties in relocating to Pakistan. Although both are highly educated (to Masters level) and have worked in Pakistan in the past, they point out that they have been out of the job market there for some time and that they may find it difficult to find work upon their return. I was shown no evidence to demonstrate that such fears are well-founded. Both of these adults are familiar with Pakistani society. They are educated and resourceful. I note that their witness statements were silent about whether they have family members in that country to whom they could turn for support if necessary. Mindful that the burden of proof lies on the Appellants in such matters I am not satisfied that there is a real risk that this family would face significant *practical* difficulty in economically providing for themselves.

46. I am however very concerned about the ability of R to safely access education, and for the reasons I shall explain, I believe that this will have significant repercussions for the family as a whole.

47. It is abundantly clear that R is no ordinary pupil. Her school has commendably played an important role in keeping her well, and has permitted up to six teachers to undertake specialist training in how to manage her condition. This does not simply mean that they keep an eye on her. It means a daily routine of measuring blood glucose levels, weighing food accordingly, and supervising her insulin injections. They are trained to spot, and deal with, her becoming unwell. This is labour intensive, and entirely necessary. Without this training and willing, I am quite satisfied that R would not be able to attend school at all.

48. I am further satisfied that there is not the remotest chance of R receiving that level of care, nor anything approaching it, in Pakistan. There is no evidence before me to indicate that schools, whether state sector or private, would enable or permit their staff to undertake such a role. The evidence uniformly indicates that there is a general ignorance about Type 1 diabetes, even in the medical profession. It is therefore extremely unlikely that teachers would have the requisite skills. I have no reason to reject the evidence of R's aunt to that effect, particularly since it is supported by the newspaper and academic articles supplied by the Appellants. Furthermore I cannot be satisfied that teaching staff would be willing to obtain such skills and deliver such care.

49. I am therefore satisfied that for R the immediate consequence of return to Pakistan would be that she would stop going to school. If her parents want to keep her safe, the only option realistically open to them would be to keep her at home, where they can undertake the monitoring and treatment tasks currently performed throughout the day by R's primary school teachers.

50. In her submissions Ms Malhotra emphasised the significance of education, and that the interference with it would be contrary to R's best interests, but in fact for the purpose of the rule the inaccessibility of schools raises a more fundamental problem. That is that R's world will immediately shrink. At present the evidence – from Ms Tranter, Ms Church and Ms Coates - is to the effect that R is a happy and outgoing child who has lots of friends and socialises well with her peers. Such relationships are obviously of fundamental importance to a child, and play a vital role in her development. The consequence of removal would be that all such relationships, and the opportunity to play and learn from others, would be a distant memory. I find that this would be a significant interference with R's private life within the meaning contemplated in Kamara: it is very difficult to see how, confined to her parents' home, she would be able to "build up within a reasonable time a variety of human relationships to give substance to [her] private or family life". Outwith the home R is, on the evidence before me, likely to encounter not only medically dangerous circumstances, but social stigma, suspicion and even hostility. So whilst she *may* be able to access education (ie through a private tutor) and her parents *may* be able to find and pay for private medical care (for which see below) the effect of return to Pakistan for R will be an effective nullification of Article 8 rights with anyone bar her immediate family.

51. I am satisfied that this self-confinement is also likely to have very serious consequences for R's parents. Presumably at least one of them will need to work in order to maintain the family, and if necessary pay for R's medical bills. That will mean that the other is left at home to care for R, in all probability her mother HK, her world shrinking at the same rate as her daughter's.

52. It follows that I am satisfied that the test in 276ADE(1), as it is truly understood, is met in these cases. The immediate consequence of return will be that for R, and at least one of her parents, their 'private lives' will be limited to interaction with other family members within the home, it simply being too dangerous to permit R to go, on a daily basis, about her life in the way that a normal 9 year old would. I would therefore allow the linked appeals with reference to paragraph 276ADE(1) and Article 8.

53. Given its importance in the case it is appropriate however that I say something about medical care. The situation facing Type 1 diabetics in Pakistan is obviously very difficult. Insulin is "not generally available". The various tests that R uses on a daily basis to keep her safe – the "basic technologies" such as glucose testing kits, are "not generally available". Treatment for diabetes-related ailments such as sight loss are "not generally available". The government has no national plan in place to address these issues. I note that there is now a charitable foundation operating a hospital in Islamabad which offers some hope, but it is unclear

on the evidence before me to what extent it might offer the right care for R. Aside from these significant obstacles I note that there are other challenges with relocating to Pakistan. The first is the change in climate. 'Diabetes UK' report that exposure to hot weather can increase the risk of crisis for diabetics, and make life difficult for those caring for them, as heat exhaustion and dehydration can mask symptoms of more serious conditions. More significantly I have very real concerns about R's ability to access safe and genuine insulin. The government of Pakistan themselves recognise that up to 50% of drugs sold in 'pharmacies' across the country are actually substandard and inefficacious, if not completely fake. It would only take one dose of such fake or substandard insulin to place R in very significant medical danger. Having read the medical evidence I have little confidence that if admitted to hospital in such circumstances R would receive the care that she requires.

54. It is therefore the case that whilst the particular insulin that R needs *may* be available in Pakistan (whether it is, is actually unclear) her parents would in effect be playing with roulette with their daughter's life every time they purchased medication for her. Even if they could find a trusted source, they would be living with the constant stress – or terror – that what they were injecting into their daughter's stomach could in fact kill her. That is a level of anxiety that any parent would recognise as amounting to mental torture. I am quite satisfied that it would meet the 'high threshold' in 276ADE(1)(vi) and render the removal of this family disproportionate.

55. For those reasons I find that the burden of proof in respect of Article 8 has been discharged, and that the appeals should be allowed. It follows that I need not address Article 3.

Anonymity

56. The Appellants' linked appeals turn on the presence in the United Kingdom of R. Having had regard to Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 and the Presidential Guidance Note No 1 of 2013: Anonymity Orders I am concerned that identification of the adult Appellants may lead to identification of R and I therefore consider it appropriate to make an order in the following terms:

> "Unless and until a tribunal or court directs otherwise, the Appellants are granted anonymity. No report of these proceedings shall directly or indirectly identify them or any member of their family. This direction applies to, amongst others, both the Appellants and the Respondent. Failure to

comply with this direction could lead to contempt of court proceedings"

Decisions and Directions

57. The decision of the First-tier Tribunal is set aside.

58. I remake the decision in the appeal as follows: "the appeal is allowed on human rights grounds".

59. There is a direction for anonymity.

Upper Tribunal Judge Bruce
25th June 2019