Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: HU/51990/2021;
HU/51991/2021; HU/51992/2021
[UI-2022-000408; UI-2022-000409; UI-2022-000410]
(IA/06443/2021, IA/06444/2021, IA/06445/2021)

THE IMMIGRATION ACTS

Heard at Field House	**Decision & Reasons Promulgated**
on 19 May 2022	**on 6 September 2022**

Before

UPPER TRIBUNAL JUDGE BLUM

Between

SADIYABANU SHAIKH
JUNEDSHAIKH
MOHMED SHAIKH
(ANONYMITY DIRECTION NOT MADE)

Appellants

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the appellant: Mr Z Malik QC, Counsel, instructed by Prime Law Solicitors
For the respondent: Ms A Nolan, Senior Home Office Presenting Officer

DECISION AND REASONS

1. These are appeals against the decision of Judge of the First-tier Tribunal Shiner ("the judge") who, in a decision promulgated on 26 January 2022, dismissed the appeals of Sadiyabanu Shaikh ("first appellant"), Juned Shaikh ("second appellant"), and Mohmed Shaikh ("third appellant") against the decisions of the Secretary of State for

the Home Department ("respondent") dated 5 May 2021 which refused their human rights claims based on Article 3 ECHR (medical grounds).

Background

2. The appellants are all nationals of India. The first and second appellants are husband and wife, and the third appellant is their minor son. They lawfully entered the UK on 19 January 2020 as visitors. They were granted further leave to remain on two further occasions as a result of the Covid-19 pandemic.

3. On 3 April 2020 the appellants applied for leave to remain on the basis that requiring them to leave the UK would breach Articles 3 and 8 ECHR and would therefore be unlawful under section 6 of the Human Rights Act 1998. These applications were principally based on the medical condition of the first appellant, with the remaining appellants dependent on her claim (see the skeleton argument before the First-tier Tribunal).

4. The first appellant suffers from Limb-Girdle Muscular Dystrophy (LGMD) and severe Dilated Cardiomyopathy MD and ARVD (Arrhythmogenic Right Ventricular Dysplasia) (summarised as 'SDC' by the judge), a progressive muscle-wasting condition that affects, amongst others, the heart. The judge described LGMD as, "… a progressive condition affecting both limb and heart muscles causing weakness initially in the hip and shoulder muscles spreading down to the limbs and heart causing heart failure" [41]. The judge accepted that the first appellant was already suffering from heart failure and cardiac arrhythmia as a consequence. The judge also accepted that LGMD (although he may have actually meant SDC) was associated with a high risk of sudden death even at a very young age [43].

5. The first appellant was aware that she had LGMD and SCD before she entered the UK. She had a cardiac defibrillator implanted in this country on 27 August 2020. Mr Malik QC did not demur when I suggested at the outset of the error of law hearing, based on the medical evidence, that this defibrillator both monitored and regulated the first appellant's heart, an approach to the evidence that had been adopted by the judge [43]. The first appellant receives a multidisciplinary approach to her condition.

6. The third appellant has inherited LGMD from his mother. There was however relatively limited evidence in respect of any treatment and monitoring that he was undergoing.

7. The second appellant suffers from type II diabetes and depression which he relates to the stress brought on by worry in respect of the first and third appellants.

8. Having considered the medical evidence presented to her, and having regard to information obtained from responses to several Medical Home Office Country of Origin Information (MedCOI) requests, and with reference to several websites concerning muscular dystrophy treatment in India and severe dilated cardiomyopathy and cardiac care, the respondent considered that India had a functioning healthcare system that was capable of assisting the appellants and that the first appellant would not face a real risk of being exposed to a serious, rapid and irreversible decline in her state of health resulting in intense suffering or a significant reduction in life expectancy as a result of the absence of appropriate medical treatment or lack of access to such treatment. The respondent considered that the appellants would be able to access treatment in India and that they had not provided evidence that they would be exposed to a real risk of treatment contrary to Article 3 ECHR. The respondent noted that, at the time of her decision, the first appellant was "only being monitored" and was "not under an active treatment programme."

9. The appellants appealed the respondent's decisions to the First-tier Tribunal under s.82 of the Nationality, Immigration and Asylum Act 2002 (the 2002 Act).

The decision of the First-tier Tribunal

10. The judge had before him bundles of documents prepared by both parties. The respondent did not field a Presenting Officer for the hearing. The judge heard and recorded oral evidence from the first and second appellants and the submissions of Mr Malik QC.

11. In his decision the judge considered the medical evidence in detail. He noted at [44] the evidence from Dr Konstantinos Savvatis, Consultant Cardiologist in Inherited and Acquired Cardiomyopathies, that the cause of sudden death in patients suffering from LGMD and SDC as being either heart failure or dangerous arrhythmia, and that such patients needed treatment in multidisciplinary centres involving a cardiologist, neurologist, physiotherapist and "other specialist"(no details were provided as to the nature of this "other specialist"). It was Dr Savvatis's evidence, detailed in a letter dated 8 October 2021, that the first appellant needed to be managed in a highly specialised centre with a multidisciplinary approach, and that the centre in which the Consultant worked was one of the few centres in the UK with knowledge of the condition. Dr Savvatis stated that the first appellant's removal to India could "… potentially expose her health and safety to high risk of deterioration of both her heart ad [*sic*] muscular function in the absence of treatment in centres specialised to treat patients with her condition and also centres where advanced therapies such as heart transplantation may not be available in the UK."

12. At [45] the judge accepted that the medical evidence showed that the combination of LGMD and SDC conditions was life-threatening and that the first appellant was at risk of sudden death through arrhythmia and heart failure. The judge found that the risk of arrhythmia had lessened ("or at least any increasing risk over time had been stemmed or lessened") since the first appellant received the defibrillator. At [46] the judge accepted that the first appellant will need cardiac and blood clotting medications and lifelong monitoring of her conditions. The judge accepted that the monitoring required was multidisciplinary in nature involving cardiologist, neurologist, physiotherapist and "other specialist". The judge accepted that the mortality for this condition could be reduced by the use of such a team.

13. Although the judge did not accept that Dr Savvatis was qualified to comment upon the generality of the resources for cardiac or neuropathy treatment in India, as a treating cardiologist with a specialism in respect of inherited cardiac disease he was able to comment upon the first appellant's past treatment and upon whether she had previously been treated appropriately. The judge therefore accepted Dr Savvatis's evidence that the first appellant had not received appropriate medical care or treatment or medication when in India. The judge however stated, "but I do not know, because it is not particularised, what was lacking in her treatment or medication there." At [48] the judge stated that the medical evidence did not show that the first or third appellants required a heart transplant at present.

14. The judge then purported to apply the legal principles in AM (Zimbabwe) (Appellant) v SSHD (Respondent) [2020] UKSC 17 ("AM (Zimbabwe"") to the facts established by him. At [51] the judge directed himself that "it was for appellants to produce before the returning state evidence "capable of demonstrating that there are substantial grounds for believing" that if removed they would be exposed to a real risk of subjection to treatment contrary to article 3."

15. From [51] to [57] the judge directed himself in accordance with the test and approach set out in AM (Zimbabwe), and he set out relevant extracts from that decision.

16. At [58] the judge stated:

> "I note that I have no direct and little other medical evidence as the [*sic*] First Appellant's life expectancy should she remain in the UK save that she is at risk of sudden death and that her life expectancy will be improved through the proposed medications and monitoring through the multidisciplinary team (having now had the CRT-D device implanted). That team I judge is likely to change treatments for the First Appellant as and when her health changes, I acknowledge so. It seems to me little point in monitoring if that were not so. But I do not know (the evidence does not provide me) as to how that might be

> different in the event that she does not receive the medications and multidisciplinary approach as planned in the UK. It seems to me that the First Appellant needed the CRT-D device, it was not provided to her in India. I judge that it was that failure to which Dr Savvatis is referring when he says she had not received suitable treatment, at least I have no other significant evidence either (or in addition) to such particular medical failure. The Appellants have failed to show to me to the relevant standard (as per the test I have set out above), as to the extent to which First Appellant's (and Zaeem's) life expectancy will be prolonged with, or reduced without, medication and multidisciplinary monitoring. Sadly I simply cannot conclude upon the material before me, even in a general way, the effect of the medication and monitoring so far as their life expectancy. For the same reasons, and it is really the same point, the evidence does not show that there will be a serious, rapid and irreversible decline in health resulting in intense suffering.
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> 59. Moreover I have no clear evidence as to whether (and if so when) she might require a heart transplant for the reasons that I have set out above. But I find that the First Appellant does not require a heart transplant at present and may never. The medical evidence does not say that one will be required, but I accept that it is probably a last treatment option.

17. At [60] the judge stated:

> "I have regard to Dr Raheem's evidence, he confirms that the First Appellant requires a multidisciplinary team and a pacemaker [I judge she has it - the CRT-D]. He further states "in the future or heart transplant (sic) too. In India only few centre have this availability with a waiting list of more than two years". It is not entirely clear to me whether he is suggesting that the heart transplant is a wait of two years, or the pacemaker or the use of the specialist centre. But I note also that there are only a few centres in the UK that provide what it is said the First Appellant requires."

18. At [61] the judge found that the first appellant had been receiving treatment in India and that her medics knew of the significant of her conditions. The judge accepted that "such treatment was inadequate in respect of her cardiac and neuro muscular medical requirements." The judge accepted the observations by Dr Savvatis regarding the first appellant's treatment in India, but he indicated that he had:

> "… no particulars as to what such failings were or why they might be repeated given the changed medical circumstances - except that she required a CRT-D. She now has the CRT-D and is on medication which I judge is appropriate for her. Such a finding (even having regard to the possibility of a waiting list for specialist treatment in India) falls short of evidence capable of demonstrating that there are substantial grounds for believing that if removed the First Appellant … would be at real risk of treatment contrary to article 3. Not least because the evidence is not capable of demonstrating that the First Appellant's … life expectancy will be reduced significantly or at all upon return to India compared to her life expectancy in the UK."

19. At [63] *et seq* the judge considered, in the alternative, that even if he was wrong in respect of the first appellant failing to meet the prima facie requirement of the AM (Zimbabwe) test, the respondent had shown that there was suitable medical treatment available in India. The judge first noted that, although treatment centres may not be widely available, they were not widely available in the UK. The judge referred to background evidence provided by the respondent (MedCOI) indicating the availability of "cardiac in and outpatient and therapy", and inpatient and outpatient neurology care including physiotherapy. At [64] the judge referred to websites relied on by the respondent which identified cardiology hospitals, some of which undertook heart transplants, and the existence of cardiac rehabilitation programs, exploratory and investigator technologies and intensive and critical care. The judge found that this evidence established that there was advanced cardiac and neurological care and treatment available in India. The judge also acknowledged the high demand for such services given the size of the Indian population.

20. At [65] the judge stated that no claim had been made by the appellants "… as to costs or other practical difficulty in accessing treatment in India." The judge noted that the appellants were able to travel to the UK and to access treatment in the UK, and the Reasons For Refusal Letters referred to the appellants as owning two businesses in India. They were also able to satisfy the respondent that they were financially stable by way of bank statements.

21. At [67] to [69], under the heading "Section 55", the judge considered the position of the third appellant, noting that he has LGMD but that there was only limited evidence of his particular medical circumstances. The judge found that it would be in his best interests to remain under the care of both of his parents. The judge finally considered the Article 8 ECHR private lives of the appellants but concluded that their removal would not be unlawful under section 6 of the Human Rights Act 1998.

22. The appeals were dismissed.

The challenge to the judge's decision

23. I summarise the grounds of appeal as settled by Mr Malik QC which he expanded at the 'error of law' hearing.

24. The first ground of appeal contends that the judge misdirected himself at [58] of his decision as to the correct test in AM (Zimbabwe). In that paragraph the judge found that "the evidence does not show that there will be a serious, rapid and irreversible decline in health resulting in intense suffering", but the test was whether the first appellant would be "exposed" to a serious, rapid and irreversible decline. Further, based on the judge's acceptance at [45] that the first appellant's condition was life-threatening and that she was at risk of

sudden death, she was “at imminent risk of dying” in the sense understood in AM (Zimbabwe) and the test was therefore satisfied. The judge, it is argued, misdirected himself by proceeding on the basis that the first appellant also had to meet the alternative formulations when, on his own findings she was “at imminent risk of dying”.

25. The second ground contends that the judge’s findings were internally inconsistent and legally flawed. Criticism is made of the judge’s assertion at [59] that he had “no clear evidence as to whether (and if so when) [the first appellant] might require a heart transplant for the reasons that I have set out above.” This was said to be ambiguous. If the judge meant to say that there was no evidence at all, this was irreconcilable with the account of all the evidence in the judge’s decision. If the judge accepted there was evidence but did not consider that it was “clear”, this begged the question as to why the judge did not consider the evidence to be “clear”. Moreover, there was no need for the judge to require “clear evidence” from the appellant; the burden was to produce evidence that was capable of demonstrating that there were substantial grounds.

26. The same ground of appeal contends that the judge’s finding at [62] that the first appellant failed to meet the prima facie requirement of demonstrating the existence of substantial grounds for believing that there would be a violation of Article 3 ECHR, was irreconcilable with his own findings at [39]-[49]. This included, inter-alia, findings that the appellant had a “life-threatening” condition, that her condition was “progressive” and that heart failure was “a consequence”, the fact that there was no cure and that she suffered “shortness of breath after a five-minute walk”, that the appellant was at “high risk of sudden death” and that she “requires ongoing follow-up and lifelong close monitoring to prevent further deterioration and to reduce the risk of sudden death”. The grounds also referred to the finding that the first appellant’s previous treatment in India was “inadequate both from the cardiac and the neuromuscular side of things which has posed a danger to her life and to that of her son’s”, that she will “need cardiac and blood clotting medications and lifelong monitoring of her condition”, and that the “monitoring required is multidisciplinary in nature involving cardiologist, neurologist, physiotherapist and other specialist” and that the mortality for this condition can be reduced by use of such a team. The grounds also list, as part of the record of evidence, the assertion by Dr Savvatis in his letter of 2 June 2021 that the first appellant’s return to India could “potentially expose her health and safety to high risk of deterioration of both her heart and muscular function in the absence of treatment in centres specialised to treat patients with her condition and also centres where advanced therapies such as heart transportation may not be available as in the UK”.

27. The third ground of appeal contends that the judge conflated the "availability" of medical treatment in India with "accessibility", and in that respect he made irreconcilable findings. The issue of accessibility had been raised in paragraph 17 of the skeleton argument before the First-tier Tribunal. The judge's reference at [63] to suitable treatment being "available in India" failed to apply the proper test which could also be met if there was a "lack of access to such treatment". The third ground referred to evidence given by the first appellant herself at [28] that medical treatment was not accessible for two years, and, at [31], the judge recorded evidence from Dr Raheen which included a reference to "a waiting list of two years." It was submitted that the judge didn't grapple with this letter. In the circumstances the judge was not entitled to find that medical treatment was immediately accessible to the appellant in India in order to manage the risk of imminent death and other consequences. Nor had the judge taken into account the evidence he recorded and accepted at [44] from Dr Savvitas that the first appellant's previous treatment in India was inadequate both from the which has posed a danger to her life.

Discussion

28. In AM (Zimbabwe) (Appellant) v SSHD (Respondent) [2020] UKSC 17 the Supreme Court considered and endorsed the judgment of the Grand Chamber of the European Court of Human Rights (the ECtHR) in Paposhvili v Belgium [2017] Imm AR 867 which gave an expanded interpretation of Article 3 ECHR in the context of medical treatment cases.

29. The appellant in AM (Zimbabwe) was settled in the UK when a deportation order was made against him because of very serious criminal offences. He was also HIV+ and claimed that he would be unable to access the appropriate antiretroviral therapy in Zimbabwe which would cause him to become prey to opportunistic infections and which, if untreated, would lead to his death.

30. The Supreme Court, having analysed Paopshvili and several other judgments, concluded that the Grand Chamber's pronouncement about the procedural requirements of Article 3 ECHR were not merely clarificatory and that the Grand Chamber had modified the earlier approach in N v United Kingdom (2008) 47 EHRR 39.

31. In Paposhvili, at [183], the ECrtHR found that an issue under Article 3 ECHR may arise in "… situations involving the removal of a seriously ill in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy."

32. At [23] the Supreme Court stated:

> "Its new focus on the existence and accessibility of appropriate treatment in the receiving state led the Grand Chamber in the *Paposhvili* case to make significant pronouncements about the procedural requirements of article 3 in that regard. It held
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> (a) in para 186 that it was for applicants to adduce before the returning state evidence "capable of demonstrating that there are substantial grounds for believing" that, if removed, they would be exposed to a real risk of subjection to treatment contrary to article 3;
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> (b) in para 187 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;
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> (c) in para 189 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;
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> (d) in para 190 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
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> (e) in para 191 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."

33. Recently in Savran v Denmark (Application No 57467/15) the Grand Chamber of the ECrtHR affirmed that Paposhvili provided a "*comprehensive standard*" in terms of mental illness as well, taking due account of all considerations relevant for the purposes of Article 3, and that it was for applicants to provide evidence capable of demonstrating that there are substantial grounds for believing that they would be exposed to a real risk of being subjected to treatment contrary to Article 3 (at [130] to [139]). It is only after this threshold has been met that the returning state's obligation to dispel any doubts which have been raised, and if necessary, seek assurances, comes in to play.

The first ground

34. This ground contends that the judge misdirected himself at [58] in respect of the test for determining a breach of Article 3 ECHR set out in AM (Zimbabwe). It is argued by Mr Malik QC that the failure of the judge to refer to the first appellant being "exposed" at the end of [58]

indicates that the judge required certainty of there being either a serious, rapid and irreversible decline in the first appellant's state of health resulting in intense suffering, or certainty that there will be a significant reduction in life expectancy. If the judge applied the correct test he would have found that there would be an "exposure" to the specified consequences on his own findings.

35. Having considered the actual medical evidence at [41] to [48], and having previously referred to the standard of proof at [31], the judge set out an extract from Paposhvili at [51] relating to the appropriate test for establishing a prima facie case, and accurately posed to himself, at [55] and [56], the approach that he needed to take as set out at [31] to [33] of AM (Zimbabwe). At [56] The judge stated:

> "Thus I must first consider whether the Appellants have adduced evidence capable of demonstrating that there are substantial grounds for believing that if removed the Appellants or any one of them would be exposed to a real risk of subjugation to treatment contrary to article 3 if returned to India."

36. This was a proper direction in respect of the relevant test.

37. The last sentence of [58] cannot be read in isolation. Earlier in the paragraph the judge found that the appellants failed to show "… to the relevant standard (as per the test I have set out above), as to the extent to which First Appellant's … life expectancy will be prolonged with, or reduced without, medication and multidisciplinary monitoring." The "test set out above" must relate to the test identified by the judge at [56]. This specifically referred to the need for there to be substantial grounds for believing that removal of the first appellant would expose her to a real risk of being subjected to Article 3 ECHR treatment if removed to India.

38. I do not consider the failure by the judge to refer to the first appellant being "exposed" to "a serious, rapid and irreversible decline", in the context of the last sentence of [58], is a legal error. The judge's assessment of whether a prima facie case had been established was undertaken with reference to the requirement that there were 'substantial grounds' for believing that the removal would expose the 1st appellant to a real risk of being subject to treatment contrary to Article 3 ECHR. The test at [31] of AM (Zimbabwe) requires evidence capable of showing that there are substantial grounds for believing that the first appellant would face a real risk, on account of the absence of appropriate treatment in India or lack of access to such treatment, "of being exposed to a serious, rapid and irreversible decline in … her state of health resulting in intense suffering or to a significant reduction in life expectancy." The term "exposure", understood in its proper context, does not add a further layer of risk. A person would be exposed to a real risk of either (a) a decline in health resulting in intense suffering or (b) a significant reduction in

life expectancy if substantial grounds had been shown that there was a real risk of this happening.

39. At [61] the judge again direct himself in accordance with the correct test when determining whether there were "… substantial grounds for believing that if removed the First Appellant … would be at real risk of treatment contrary to article 3." Reading the decision 'in the round', I am not persuaded that the judge required certainty that the first appellant's life expectancy would be significantly reduced or that there would be a serious, rapid and irreversible decline in her health resulting in intense suffering.

40. There is no merit in Mr Malik QC's argument that the first appellant was at "imminent risk of dying". The fact that the first appellant is at risk of sudden death through arrhythmia and heart failure is not to be equated with someone who is at 'imminent risk of dying' in the sense understood in N v SSHD [2005] UKHL 31 and D v United Kingdom [1997] 24 EHRR 423, which generally concern a person whose life is drawing to a close and who is in the advanced states of a terminal and incurable illness. Whilst the first appellant was at high risk of a sudden death, that event, on the evidence before the judge, could not on any rational view be considered 'imminent'.

The second ground

41. The criticism in the second ground of appeal in respect of the judge's claim that there was "no clear evidence" related to whether the first appellant might require a heart transplant. The judge, at [59] asserted that the reasons for the absence of "clear evidence" had been given for the reasons he set out "above". I asked Mr Malik QC to take me to the evidence that was before the judge relating to whether the appellant might require a heart transplant. Mr Malik QC referred me to [27], which summarised the first appellant's oral evidence. She is recorded as saying that "the doctors had suggested a heart transplant in the future." Mr Malik QC also referred me to [28], which continues the record of the first appellant's oral evidence. The judge had put to the first appellant that the Reasons For Refusal Letter contained information as to the availability of heart transplant surgery. The first appellant responded, "It is there but the treatment I have received is inadequate." Mr Malik QC also drew my attention to [44] in which the judge summarised some of the documentary medical evidence. This included a reference to a letter from Dr Savvitas which mentioned that the first appellant will require close and lifelong follow-up for her risk of sudden death and "in the future consideration for heart transplantation."

42. In my judgement, having regard to the evidence before the First-tier Tribunal, it was open to the judge to conclude that the evidence as to whether the first appellant might require a heart transplant was not "clear". It is readily apparent from the context of the paragraph and

the evidence before the judge that the reference to an absence of 'clear evidence' meant an absence of evidence that was detailed or conclusive. The evidence previously recorded by the judge in his decision at [27], [28], [44]and [48], indicated that the appellant may be considered in the future for a heart transplant. The judge was rationally entitled to find that the evidence as to whether the first appellant would require a heart transplant was 'unclear'.

43. I reject Mr Malik QC's contention that the judge erred in law by requiring there to be "clear" evidence. The reference to "clear evidence" was purely in respect of whether the first appellant may require a heart transplant in the future. There is nothing in the decision, read as a whole, to indicate that the judge's reference to "clear evidence" led to a misapplication of the burden and standard of proof in respect of his findings. The use of the word 'clear' was a description of the quality of the evidence relating to the likelihood of the first appellant requiring a heart transplant. Nor does an assertion that there is no "clear evidence" mean that the judge has applied a higher requirement on the appellant than is required by the AM (Zimbabwe) test, which itself has a relatively high threshold (see [32] of AM (Zimbabwe), as referenced at [56] of the judge's decision).

44. The second ground further contends that the judge's findings were irreconcilable with his conclusion that the first appellant failed to meet the 'prima facie' requirement in the AM (Zimbabwe) test.

45. With respect to the procedural requirements of Article 3 ECHR, the appellants are required to present evidence "capable of demonstrating that there are substantial grounds for believing" that Article 3 ECHR would be violated. This would occur if there were substantial grounds for believing that the first appellant would face a real risk, on account of the absence of appropriate treatment in India or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in her state of health resulting in intense suffering or to a significant reduction in her life expectancy.

46. The various findings and record of evidence detailed at [11] of the Grounds of Appeal, summarised at [26] above, must be considered in light of the judge's findings in respect of the evidence relating to the first appellant's life expectancy in the UK, as well as the evidence of the absence of appropriate treatment or lack of access to such treatment in India. At [58] the judge considered that he had "… no direct and little other medical evidence as to the First Appellant's life expectancy should she remain in the UK save that she is at risk of sudden death and her life expectancy will be improved through proposed medications and monitoring through the multidisciplinary team." In the same paragraph the judge indicated that he did not know (as the evidence did not provide) as to how the first appellant's situation "might be different in the event that she does not receive the medications and multidisciplinary approach as planned in the UK."

These were conclusions rationally open to the judge based on the evidence before him and his assessment of that evidence, and which were not rationally inconsistent with his other findings.

47. The judge additionally supported his conclusions that no 'prima facie' case had been made out on the basis that the inadequacy of the first appellant's previous treatment in India related to the failure to provide her with the CRT-D device [58]. This was a conclusion rationally open to the judge given the relative dearth of detail in the evidence from Dr Savvatis. The judge then noted, at [62], that the first appellant now had a CRT-D. The judge additionally considered the letter from Dr Raheem. This letter was brief and lacked clarity. The judge was entitled, at [60], to find that "It is not entirely clear … whether [Dr Raheem] is suggesting that the heart transplant is a wait of two years, or for the pacemaker or the use of the specialist centre." The letter from Dr Raheem did not clearly specify what was the subject of a two-year waiting period. One would have reasonably expected it to do so. It was for the first appellant to present evidence that there were substantial grounds for believing that the appropriate treatment, monitoring and support required to prevent a breach of Article 3 ECHR was not available in India. Faced with evidence that was vague and lacking in clarity, and in circumstances where the position of the first appellant was different to that when she lived in India because she now had implanted the CRT-D pacemaker/defibrillator, it was open to the judge to find that the prima facie case had not been made out, and this conclusion was not inconsistent with his findings or the record of evidence.

The third ground

48. I do not accept that the judge conflated the 'availability' of medical treatment in India with the 'accessibility' of such treatment in India. A holistic consideration of the decision indicates that the judge both appreciated and engaged with the issue of accessibility of medical treatment.

49. The judge made specific reference to the submission made on behalf of the appellants that "availability is one thing, accessibility is another" [31]. At [54] the judge set out exerpts from AM (Zimbabwe) dealing with the approach by a returning state to verify on a case-by-case basis whether the care generally available and accessible was sufficient to prevent a breach of Article 3 ECHR. At [57] the judge set out further extracts from Paposhvili cited with approval by the Supreme Court in AM (Zimbabwe), including, at [190], an extract indicating that the authorities must also consider whether an individual would have access to the necessary care and facilitates in the receiving state. Then at [65] the judge expressly engaged with issues relating to accessibility of medical treatment, noting that no claim was made by the appellants "… as to cost or other practical difficulty in accessing treatment in India (at [36] the judge referred to

the Refusal Letter which noted that the appellants appeared financially stable in India as the owned two businesses).

50. The third ground criticises the judge for failing to grapple with the letter from Dr Raheen. As detailed at [47] above, the judge did 'grapple' with Dr Raheen's letter. The judge found that the letter was unclear as to the nature of the 'waiting list of two years'. There was a lack of evidence produced by the first appellant that a multidisciplinary approach was not accessible in India for this particular appellant because of any waiting list, and there were no further details relating to this waiting list other than the assertion by Dr Raheen in his brief letter. The only other evidence relating to the accessibility of the appropriate medical treatment in India based on a waiting list was from the first appellant herself, but no details were provided by her as to the source of her assertion. I note that in her answers to questions put by the judge the first appellant agreed that there were physiotherapy and neurological services in India.

51. The third ground additionally relies on the judge's acceptance of the evidence of Dr Savvatis that the first appellant's previous treatment in India had been inadequate. This however is to ignore the judge's findings at [48] and his observations at [61] that Dr Savvatis did not particularise what was lacking in the first appellant's previous treatment in India, and his finding at [58] that the failure of treatment to which Dr Savvatis was referring was the failure to provide her with the CRT-D device.

52. Having regard to the decision as a whole, I am not persuaded that the judge conflated the issues of the availability and the accessibility of medical treatment for the first appellant in India.

Notice of Decision

The First-tier Tribunal's decision did not involve the making of an error on a point of law requiring the decision to be set aside

The appeals are dismissed

Signed D.Blum Date: 20 July 2022

Upper Tribunal Judge Blum