Upper Tribunal
(Immigration and Asylum Chamber)

Appeal Number: IA/00383/2014
IA/00393/2014
IA/00397/2014
IA/00402/2014

THE IMMIGRATION ACTS

Heard at Birmingham	**Decision and Reasons Promulgated**
On 23 July 2015	**On 3 September 2015**

Before

UPPER TRIBUNAL JUDGE PITT
DEPUTY UPPER TRIBUNAL JUDGE SAFFER

Between

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Appellant

and

MTH
RS
MTT
TZ
(ANONYMITY ORDER MADE)

Respondents

Representation:
For the Appellant: Mr Smart, Senior Home Office Presenting Officer
For the Respondents: Mr Azmi, instructed by Kingswood Legal Ltd

DECISION AND REASONS

1. The appellant before us was the Secretary of State for the Home Department. For the sake of consistency with the decision in the First-tier Tribunal we shall refer to her as the respondent and to MTH, RS, MTT and TZ as the appellants.

2. Pursuant to Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI 2008/269) we make an anonymity order. Unless the Upper Tribunal or a Court directs otherwise, no report of these proceedings or any form of publication thereof shall directly or indirectly identify the original appellants. This direction applies to, amongst others, all parties. Any failure to comply with this direction could give rise to contempt of court proceedings. We do so in order to preserve the anonymity of the children, one of whom has a serious medical condition.

I. Background

3. All of the appellants are nationals of Bangladesh. MTH and RS are father and mother to MTT who is aged 14 and TZ who is aged 6.

4. The key facts in this appeal are summarised in Upper Tribunal Judge Pitt's error of law decision dated 10 June 2015 (appended):

> "4. The appellants are a family from Bangladesh. They came to the UK in order for RS to study for an MSc at Birmingham University which she was subsequently awarded.
>
> 5. The family made an application for further leave to remain on Article 8 grounds as MTT is very unwell. He has tufting enteropathy which is incurable. He is unable to digest food through his stomach and requires parenteral nutrition. This procedure involves the insertion of a catheter into a blood vessel close to his heart through which he is fed intravenously for approximately 12 hours each day, seven days a week. The facilities provided in the UK have enabled him to do this whilst he moves around carrying a bag of nutritional solution. His parents have been trained to administer his nutrition.
>
> 6. Prior to coming to the UK, MTT received similar treatment in Singapore but his parents are concerned about returning there for treatment as he was not diagnosed correctly initially when there and caught serious infections twice in the three week period that he was treated.
>
> 7. The family are also concerned that provision for parental nutrition is not available at all in Bangladesh and even if were it would be very difficult to administer as the nutritional solution has to be kept between 2 and 8 degrees. MTT was very ill and underweight prior to travelling to Singapore and the UK."

5. It was common ground before us that the appeal is brought on Article 8 ECHR private life grounds and turns on the serious medical condition of MTT.

6. The family cannot meet the private life requirements of paragraph 276ADE of the Immigration Rules. The parties therefore addressed us on a second

stage Article 8 assessment of the private life of the family outside the provisions of the Immigration Rules; MF (Nigeria) v SSHD [2013] EWCA Civ 1192 and SS (Congo) v SSHD [2015] EWCA Civ 387 applied.

II. Legal Principles to be applied in Second Stage Article 8 Assessment

7. We have conducted the second stage Article 8 assessment in line with the well-established principles of R (Razgar) v SSHD [2004] UKHL 27 and Huang v SSHD [2007] UKHL 11.

8. When assessing proportionality, we bore in mind that, notwithstanding the provisions of the Immigration Rules which express the respondent's legitimate view of what will usually amount to a successful Article 8 claims it remains the case, as confirmed in [29] of SS (Congo) that:

> "It is clear, therefore, that it cannot be maintained as a general proposition that LTR or LTE outside the Immigration Rules should only be granted in exceptional cases."

9. However, this is an Article 8 "medical" case and the Court of Appeal in the cases of MM (Zimbabwe) v SSHD [2012] EWCA Civ 279 and GS (India) v SSHD [2015] EWCA Civ 40 has also indicated that there is a high threshold for a claim on that basis to succeed.

10. MM dealt with a mentally ill offender, his offending arising from his mental ill health. The discussion of how an Article 8 "medical" claim could succeed is at [16] to [24]:

> ***"Article 3 and Article 8***
>
> 16. The first issue with which this appeal is concerned relates to the application of Article 3 and Article 8 of the Convention to cases where it is sought to compare the availability of medical treatment in the United Kingdom with the country to which it is proposed to deport an applicant. The decisions of the House of Lords and of the European Court of Human Rights establish that even where a claimant is suffering from mortal illness such as advanced HIV/Aids and, if deported, would deteriorate rapidly and suffer an early death, no breach of Article 3 is established.
>
> 17. The essential principle is that the ECHR does not impose any obligation on the contracting states to provide those liable to deportation with medical treatment lacking in their "home countries". This principle applies even where the consequence will be that the deportee's life will be significantly shortened (see Lord Nicholls in *N v Home Secretary* [2005] 2 AC 296, 304 [15] and *N v UK* [2008] 47 EHRR 885 (paragraph 44)).
>
> 18. Although that principle was expressed in those cases in relation to Article 3, it is a principle which must apply to Article 8. It makes no sense to refuse to recognise a "medical care" obligation in relation to Article 3, but to acknowledge it in relation to Article 8. In *N v UK*, the ECHR took the view that no separate issue under Article 8 arose [517].
>
> 19. Despite that clear-cut principle, the courts in the United Kingdom have declined to say that Article 8 can never be engaged by the health

consequences of removal from the United Kingdom. In *R(Razgar) v Home Secretary* [2004] 2 AC 368, the question of principle was whether the rights protected by Article 8 could be engaged by the foreseeable consequences for health or welfare of removal of the United Kingdom pursuant to an immigration decision, where such removal does not violate Article 3 [1]. Lord Bingham's answer was that such rights could be engaged by the foreseeable consequences for health of removal from the United Kingdom, even where such removal does not violate Article 3, "if the facts relied on by the applicant are sufficiently strong" [10]. Lord Steyn agreed with Lord Bingham. Lord Walker agreed with Lord Bingham's observation and Lord Carswell considered the question to be whether removal would amount to a "flagrant denial of the appellant's Article 8 rights to the preservation of his mental stability" [74].

20. Baroness Hale admitted of the possibility that in a case where removal will lead to a violation of a person's convention rights in the country to which he is to be removed (a "foreign case") a case could fail under Article 3 but succeed under Article 8. But she acknowledged:-

> "Although the possibility cannot be excluded, it is not easy to think of a foreign health care case which would fail under Article 3 but succeed under Article 8. There clearly must be a strong case before the Article is even engaged and then a fair balance must be struck under Article 8(2). In striking that balance, only the most compelling humanitarian considerations are likely to prevail over legitimate aims of immigration control or public safety. The expelling state is required to assess the strength of the threat and strike that balance. It is not required to compare the adequacy of the health care available in the two countries. The question is whether removal to the foreign country will have a sufficiently adverse effect upon the applicant. Nor can the expelling state be required to assume a more favourable status in its own territory than the applicant is currently entitled to. The applicant remains to be treated as someone who is liable to expulsion, not as someone who is entitled to remain." [59]
>
> None of the other members of the Committee expressly refer to this passage.

21. Since *Razgar* this court has reiterated the principle expressed in *Bensaid (q.v. supra)* that if removal would have sufficiently adverse effect upon mental health, it is capable of engaging Article 8 (see *AJ (Liberia) v Secretary of State for the Home Department* [2006] EWCA Civ 1736 [17]). But again, the court pointed out that legitimate immigration control would ordinarily meet the test of necessity under Article 8(2) and decisions taken "*bona fide* in the exercise of such control would be proportionate in all but a small minority of truly exceptional cases, in which the imperative of proportionality demands an outcome in the claimant's favour" [18].

22. Thus the courts have declined to close the door on the possibility of establishing a breach of Article 8 but they have never found such a breach and have not been able to postulate circumstances in which such a breach is likely to be established. Since *Bensaid* in 2001 there has been no example of a successful Article 8 claim in a mental health case. The courts and tribunals have merely been left with the difficulty of identifying a "flagrant

denial" or a "truly exceptional" case, neither of which provide any standard of measurement.

23. The only cases I can foresee where the absence of adequate medical treatment in the country to which a person is to be deported will be relevant to Article 8, is where it is an additional factor to be weighed in the balance, with other factors which by themselves engage Article 8. Suppose, in this case, the appellant had established firm family ties in this country, then the availability of continuing medical treatment here, coupled with his dependence on the family here for support, together establish 'private life' under Article 8. That conclusion would not involve a comparison between medical facilities here and those in Zimbabwe. Such a finding would not offend the principle expressed above that the United Kingdom is under no Convention obligation to provide medical treatment here when it is not available in the country to which the appellant is to be deported.

24. But the question remains whether the appellant has established that deportation would infringe his rights enshrined in Article 8."

11. GS (India) v SSHD [2015] EWCA Civ 40 dealt with five appeals where the applicants had End Stage Kidney Disease and one where the applicant was at an advanced stage of HIV infection.

12. The learning of Laws LJ on Article 8 "medical" claims is at [85] to [87]:

"THE ARTICLE 8 CLAIMS

85. It is common ground that in cases where the claimant resists removal to another State on health grounds, failure under Article 3 does not necessarily entail failure under Article 8. In her skeleton argument at paragraph 55 Ms Giovanetti for the Secretary of State cites JA (Ivory Coast) & ES (Tanzania) v SSHD [2009] EWCA Civ 1353, in which the appellants had been given a "de facto commitment" that they would be allowed to remain in the UK for treatment. Sedley LJ, with whom Longmore and Aikens LJJ agreed said this at paragraph 17:

> "There is no fixed relationship between Art. 3 and Art. 8. Typically a finding of a violation of the former may make a decision on the latter unnecessary; but the latter is not simply a more easily accessed version of the former. Each has to be approached and applied on its own terms, and Ms Giovannetti is accordingly right not to suggest that a claim of the present kind must come within Art. 3 or fail. In this respect, as in others, these claims are in Mr Knafler's submission distinct from cases such as D and N, in both of which the appellant's presence and treatment in the UK were owed entirely to their unlawful entry ... ."

86. If the Article 3 claim fails (as I would hold it does here), Article 8 cannot prosper without some separate or additional factual element which brings the case within the Article 8 paradigm – the capacity to form and enjoy relationships – or a state of affairs having some affinity with the paradigm [citing paragraph 23 of MM]. "

87. With great respect this seems to me to be entirely right. It means that a specific case has to be made under Article 8. It is to be noted that MM (Zimbabwe) also shows that the rigour of the D exception for the purpose of

> Article 3 in such cases as these applies with no less force when the claim is put under Article 8 [citing paragraphs 17 and 18 MM].”

13. In GS, Underhill LJ also commented at [111] on [23] of MM:

> “… two essential points are being made. First, the absence or inadequacy of medical treatment, even life-preserving treatment, in the country of return, cannot be relied on at all as a factor engaging article 8: if that is all there is, the claim must fail. Secondly, where article 8 is engaged by other factors, the fact that the claimant is receiving medical treatment in this country which may not be available in the country of return may be a factor in the proportionality exercise; but that factor cannot be treated as by itself giving rise to a breach since that would contravene the "no obligation to treat" principle.”

14. There is the additional factor here that MTT and TZ children. Section 55 of the Borders, Citizens and Immigration Act 2009 requires us carry out our task so that it is:

> “… discharged having regard to the need to safeguard and promote the welfare of children who in the United Kingdom.”

15. At [33] of ZH (Tanzania) v SSHD [2011] UKSC 4, Baroness Hale provided guidance on to how to apply s.55 in an Article 8 case:

> “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.”

16. In the case of R (SQ (Pakistan)) v SSHD [2013] EWCA Civ 1251 the Court of Appeal addressed the question of how to approach Article 3 and 8 “medical” cases concerning a child. At [17], Maurice Kay LJ stated, in the context of an Article 3 case, that:

> “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”.

17. At [21], the Court confirmed that “*ZH (Tanzania)* demonstrates the central role of the best interests of children in an Article 8 case” and went on to consider the potential impact of the ZH principle in a proportionality assessment at [26] and [27]:

> “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.

18. The approach identified in SQ was confirmed in AE (Algeria) v SSHD [2014] EWCA Civ 653, the lead judgement again being given by Maurice Kay LJ. At [2], referring to his earlier decision:

> "2. As in the recent case of R (SQ (Pakistan)) v Upper Tribunal [2013] EWCA Civ 1251, this case is concerned with the application of Articles 3 and 8 when it is proposed to remove a very sick child to his or her home country where available healthcare provision is substantially inferior but where the evidence does not point to the likelihood of an early death. The leading authorities in "health" cases concerned adults: D v United Kingdom [1997] 24 EHRR 423; N v Secretary of State for the Home Department [2004] 2AC 296; and its sequel in the European Court of Human Rights (ECtHR), N v United Kingdom [2008] 47 EHRR 39. It is well known that these authorities place a high hurdle in the way of adult applicants in health cases. In SQ, this court accepted that there can be circumstances in which the high threshold can be reached in relation to a child where it would not be reached in the case of an adult (paragraph 17). It also accepted that, in the light of Article 3.1 of the United Nations Convention on the Rights of the Child (UNCRC) and section 55 of the Borders Citizenship and Immigration Act 2009, special considerations in relation to children arise under Article 8 of the ECHR such that the best interests of the child are "a primary consideration", as explained in ZH (Tanzania) v Secretary of State for the Home Department [2011] (UKSC4). The submissions on the present appeal to a large extent replicate those advanced in SQ. However, the cases are necessarily fact sensitive. In SQ the appeal was dismissed in relation to Article 3 but was allowed, to the extent of a remittal to the UT, in relation to Article 8."

and at [7]:

> "7. SQ shows that, particularly in relation to a child, Article 8 may be more protective than Article 3. On the other hand, where it is engaged, the fact that it concerns a qualified right means that everything will ultimately depend on the balancing exercise pursuant to Article 8.2."

19. The case law we have considered requires "other factors which by themselves engage Article 8" or "some separate or additional factual element which brings the case within the Article 8 paradigm … or a state of affairs having some affinity with the paradigm" beyond the medical issues if an Article 8 claim is to succeed where it does not under Article 3. It appeared to us that the approach taken in SQ and AE was that the minority of an appellant had that potential, Maurice Kay LJ stating at [24] that "the issue of interference must admit of only one answer here". We could not identify anything other than the appellants' minority in SQ and AE distinguishing them from, for example, N in N v UK or appellant KK in GS who was considered at [97] not to have a private life beyond that allowed by his treatment in the UK. We accepted that the minority of two of the appellants here meant that we should follow SQ and AE in finding Article 8 engaged and a proportionality assessment of the interference with private life required.

20. From this learning of the Supreme Court and Court of Appeal, we take the following principles as being of particular relevance to this appeal:

    a. The threshold in a "medical" case is very high. Even if an appellant is suffering from "mortal illness" and "would deteriorate rapidly and suffer an early death" a claim does not succeed ([16] of MM) .

    b. The very high threshold must be applied in a "medical" case brought under Article 3 and Article 8. A case will not usually succeed on the same medical evidence under Article 8 where it does not under Article 3 ([16] and [18] of MM , [87] of GS).

    c. A "medical" case that does not meet the high threshold under Article 3 can only succeed under Article 8 if there are "other factors which by themselves engage Article 8" ([23 of MM]) or "some separate or additional factual element which brings the case within the Article 8 paradigm … or a state of affairs having some affinity with the paradigm" ([86] of GS).

    d. The proportionality assessment cannot turn solely on a comparison between medical treatment available here and in Bangladesh and the consequences for the appellant although that will be one of the factors to be taken into account. To do otherwise would offend the "no obligation to treat principle" ([23] of MM and [111] of GS).

    e. The best interests of a child are to be weighed as a primary factor ([33] of ZH).

    f. MTT's minority brings the case within the Article 8 paradigm and is a factor capable of making to return to Bangladesh disproportionate when that would not be so for an adult. That will not necessarily be so as it will depend on all the factors in play in the balancing exercise ([26] of SQ and [7] of AE).

g. The assessment will be fact specific. The case law discussed above identifies relevant considerations such as legal entry and residence (SQ at [26]), entry where an appellant was already aware of illness (SQ at [27]), *de facto* assumption of care ([85] of GS), previous leave being granted in order to remain for treatment (SQ at [26]) and family support on return (AE at [4]) but there is no definitive list or guidance as to what weight might attract to these factors in different cases.

21. Before proceeding to assess proportionality we reminded ourselves of the need for "other factors which by themselves engage Article 8" or "some separate or additional factual element which brings the case within the Article 8 paradigm … or a state of affairs having some affinity with the paradigm" beyond the medical issues. The discussion in the case law above of an appellant's minority and role of s.55 is in the context of an assessment of proportionality rather than the need identified in MM and GS for there to be "additional factors" within the Article 8 paradigm that might allow for a different outcome under Article 8 than under Article 3.

22. We observed, however, that in SQ the Court of Appeal found for the minor appellant as the First-tier Tribunal had decided incorrectly that Article 8 was not engaged as interference with private life had not been shown. At [24], Maurice Kay LJ indicated that "the issue of interference must admit of only one answer here". The feature that appears to have allowed the Court of Appeal in that case to find that an Article 8 case had the potential to succeed where had not under Article 3 was that SQ was a child.

23. We are therefore satisfied that Article 8 is engaged here where there is a minor appellant and that the respondent's decision amount to an interference with the child's private life, requiring us to proceed to assess whether the interference is proportionate.

24. We are also required to apply the provisions of paragraphs 117A and 117B of the Nationality, Immigration and Asylum Act 2002; Dube (ss117A-117D) [2015] UKUT 90 (IAC) and Forman (ss 117A-C considerations) [2015] UKUT 00412 (IAC) applied. Those provisions are as follows:

> 117A Application of this Part
>
> (1) This Part applies where a court or tribunal is required to determine whether a decision made under the Immigration Acts—
>
> (a) breaches a person's right to respect for private and family life under Article 8, and
>
> (b) as a result would be unlawful under section 6 of the Human Rights Act 1998.
>
> (2) In considering the public interest question, the court or tribunal must (in particular) have regard—
>
> (a) in all cases, to the considerations listed in section 117B, and

(b) in cases concerning the deportation of foreign criminals, to the considerations listed in section 117C.

(3) In subsection (2), "the public interest question" means the question of whether an interference with a person's right to respect for private and family life is justified under Article 8(2).

117B Article 8: public interest considerations applicable in all cases

(1) The maintenance of effective immigration controls is in the public interest.

(2) It is in the public interest, and in particular in the interests of the economic well-being of the United Kingdom, that persons who seek to enter or remain in the United Kingdom are able to speak English, because persons who can speak English—

(a) are less of a burden on taxpayers, and
(b) are better able to integrate into society.

(3) It is in the public interest, and in particular in the interests of the economic well-being of the United Kingdom, that persons who seek to enter or remain in the United Kingdom are financially independent, because such persons—

(a) are not a burden on taxpayers, and
(b) are better able to integrate into society.

(4) Little weight should be given to—
(a) a private life, or
(b) a relationship formed with a qualifying partner, that is established by a person at a time when the person is in the United Kingdom unlawfully.

(5) Little weight should be given to a private life established by a person at a time when the person's immigration status is precarious.

(6) In the case of a person who is not liable to deportation, the public interest does not require the person's removal where—

(a) the person has a genuine and subsisting parental relationship with a qualifying child, and

(b) it would not be reasonable to expect the child to leave the United Kingdom.

III. Medical Evidence

25. MTT's condition is at the centre of our consideration as it is an essential element in the assessment of his private life and best interests so we start our consideration with the medical evidence that was before us.

26. We were provided with a number of letters from MTT's current treating team at Birmingham Children's Hospital. In a letter dated 10 February

2014, Dr Rafeeq Muhammed, Consultant Paediatric Gastroenterologist and Christine Holden, Head of Nutritional Care, stated:

> "[MTT] previously lived in Bangladesh for 10 years and was extremely unwell with high risk of dying due to his complex bowel problems. When he came to Britain … he was severely emaciated …. He is on life saving treatment everyday and would be in severe danger if treatment is stopped. It is not possible for this to be undertaken in Bangladesh.
>
> …
>
> Without parenteral nutrition [MTT] will have serious health problems which could result in his death. The prognosis of this condition remains poor without parenteral nutrition, however, with parenteral nutrition children can live into adulthood and have a good quality of life.
>
> This treatment is essential for [MTT]'s survival in terms of growth, development, general health and his problem maintaining his body's salt balance. … I would not recommend long distance travel for [MTT], particularly in a flight, because of the risk of dehydration and infection. [MTT] also receives treatment from Rheumatology, Endocrinology and Dental teams for problems (sic) poor bone and teeth health which are related to his bowel condition.
>
> We would hope you would look sympathetically at this appeal as [MTT] could die if the specialised treatment cannot be continued."

27. Dr Muhammed and Ms Holden confirm these views in a number of other letters. In his most recent letter dated 29 June 2015, Dr Muhammed stated:

> "With the treatment provided by the multidisciplinary team in Birmingham Children's Hospital, [MTT]'s quality of life is very good. [MTT] is also looked after by many other specialists in our hospital regarding his bone and dental health, mobility and hearing problems. We have enquired about health care facilities in Bangladesh and they do not have facilities no where (sic) near which we provide in the UK. I believe that [MTT]'s health consequences could be so severe that his life could be in danger if he is forced to move back to Bangladesh and discontinue the current treatment."

28. Christine Holden indicated in her most recent letter dated 3 July 2015:

> "[MTT] is on life saving treatment every day and would be in severe danger if treatment was stopped.
>
> …
>
> Without parenteral nutrition [MTT] will have serious health problems, which could result in his death. The prognosis of his condition remains poor without parenteral nutrition, however with parenteral nutrition children can live into adulthood and will have a good quality of life.
>
> I would not recommend long distance travel for [MTT], particularly a flight, because of the risk of dehydration and infection.
>
> …

> In view of all of the above and the needs of [MTT] and his family it is imperative they are allowed to remain in this country. I would hope you would look sympathetically at this appeal as [MTT] could die if treatment does not continue in this country."

29. The evidence was clear as to parenteral nutrition not being available at all in Bangladesh. The treatment is complex and relatively rare even in the UK with a range of regular support from hospital and community medical teams required on an ongoing basis. The expertise and equipment required is not available in Bangladesh with the additional difficulties of storage of the solution and administration in the required sterile conditions being very difficult due to the climate and erratic electricity supply.

30. We accept without hesitation that MTT has a very serious, chronic condition. We recognise that this has lead to him being very ill due to undernourishment and side-effects of treatment all his life. Complications have included weak bones and fractures due to inadequate nutrition and he has recently experienced hearing loss.

31. What we also take from the evidence of Dr Muhammed and Ms Holden, however, is that on return to Bangladesh without parenteral nutrition MTT "could" or "could probably" or "would potentially" die. Their evidence was no more specific as to the likelihood of MTT dying after return or how limited MTT's life expectancy might be.

32. It appeared to us that, although very concerning, this prognosis explained why the case did not succeed under Article 3 ECHR before the First-tier Tribunal and there was no challenge to that part of the decision. We reminded ourselves, however, that although the threshold remains high in an Article 8 "medical" case, the failure under Article 3 does not mean an Article 8 claim cannot succeed, particularly where it concerns children.

33. In addition to the evidence from the team at Birmingham Children's Hospital, we also had evidence from Michelle Snipe, Palliative Care Nurse who cares for MTT in the community. She states in her letter of 17 February 2014 that:

> "Withdrawal from this treatment package in essence would be fatal for [MTT]"

and in her further letter dated 8 July 2015 that:

> "[MTT] does not have positive memories of his life in Bangladesh as he was unwell throughout this period of his life. [MTT] has reported demonstrate (sic) anxiety and distress regarding his future and mortality at the prospect of returning to Bangladesh as he is acutely aware of the limitations that would challenge his medical and educational care."

34. Carole Benson, Paediatric Homecare Nurse comments in a letter dated 7 July 2015 that:

> "Without Parenteral Nutrition (PN) [MTT] would not grow up at all and would not survive.
>
> …
>
> Again without PN, [MTT] would have a poor quality and fore shortened (sic) existence full of pain and discomfort with no independence or active part to play.
>
> …
>
> By denying permission you are breaching his rights and condemning him to a shortened, painful and joyless life with no expectation of contributing to society.
>
> If he was forced to return to Bangladesh it is a 12 hour flight, a journey in total of almost 24 hours. This journey would be detrimental to his health as he would not be able to receive PN during the journey or after its conclusion."

35. Where Ms Snipe and Ms Benson state that absence of parenteral nutrition "would be fatal" and that MTT "would not survive" we prefer the opinion of MTT's Consultant and the Head of Nutrition at the Birmingham Children's Hospital who state only that he "could" be so at risk on return. We take that view not just on the basis of their seniority of Dr Muhammed and Ms Holden but because their opinions are consistent with the fact of MTT surviving in Bangladesh from birth to the age of 2 and then on return from 2004 to 2011 after he returned from Singapore.

36. We had a similar difficulty with the comments as to the risks to MTT's health and wellbeing if he undertakes the journey to Bangladesh. The evidence is that he flew to the UK after 7 years' of sub-optimal treatment in Bangladesh. He has now had 4 years' of treatment that has improved his health to some extent. His condition has now been definitively diagnosed and it appeared to us that plans can be made to ameliorate the risk of deterioration in his health during the journey. If necessary the journey could be undertaken in stages, with breaks, possibly in countries that can provide parenteral nutrition, his parents indicating in their witness statement, for example, that MTT received this treatment in Singapore when he was a young child.

Circumstances on Return to Bangladesh

37. We had the evidence set out above from the medical team in the UK on MTT's health and likely circumstances on return to Bangladesh. We also heard evidence from MTT's father, MTH, about how the family dealt with MTT's health problems when they were in Bangladesh from 2004 to 2011, those conditions realistically being those he would be returning to now.

38. We found the dignified and straightforward manner in which MTH gave his evidence on such acutely difficult matters deeply impressive.

39. MTH told us that life in Bangladesh had been a struggle for MTT. Every week he had to go to hospital for treatment. At the hospital he was given glucose and protein lipid drips via a vein which was very unpleasant. Every two or three days the vein would become blocked and other veins used, all of which was very painful for MTT. A great deal of MTT's life was staying in bed at home. MTH and RS were both working in Bangladesh before they came to the UK. Together with RS's mother and a maid who lived in the flat opposite, they cared for MTT.

40. MTH accepted that the family are privileged. They had enjoyed a high standard of living in Bangladesh and could expect to return to the same. MTH is a Deputy General Manager of the Central Bank of Bangladesh. His wife, RS, works for the Bangladesh Government as a senior Assistant Chief in the Ministry of Planning. MTH commented that her post-graduate degree from the University of Birmingham will assist her in her furthering her career. In addition. three of MTT's aunts are doctors, two of them Professors, an uncle is in the banking sector, and another uncle is a Lieutenant Colonel in the army. Relatives in Bangladesh have been sending money to help the family. MTH confirmed this was for living costs and that the family had not paid for the treatment or the education MTT and ZT had accessed in the UK.

41. MTH accepted that the family could recreate the same system of care for MTT on return as had been in place before they left Bangladesh but this was very difficult for them to contemplate.

42. In particular, MTT had spoken to MTH asking him not to allow him to be returned to Bangladesh as he feared he would die. We noted that that is the view he also expressed to Ms Snipe at [30], above. It was also mentioned by MTT's Family Support Worker, Sonia Grant, who wrote in a letter dated 26 June 2015 that he is fearful of returning to Bangladesh as he was so unwell when he lived there.

43. We accept that MTT's quality of life in Bangladesh will be very poor, that he will once again become mainly house-bound, if not often bed-bound, will not be able to have a life of much substance outside the home and will really only socialise with his immediate relatives. He will have a high level of family support, possibly more so than now where he has only his parents with him rather than grandparents and aunts and uncles.

44. We also accept that he will not be able to go to school, make friends and socialise as he has here. The family has already established that even private schools in Bangladesh would find it difficult to address his needs by way of equipment and personal support were he well enough to attend. His father has indicated that the family can pay for private tuition but this can only provide a limited form of education compared to that he has been able to access in the UK. Slightly more positively, we noted that his Family Support Worker identified IT as a favourite subject and that he enjoys TV

and computer games, aspects of his current life that could be replicated in his home in Bangladesh.

IV. Article 8 Assessment

Best Interests

45. It is obvious to us that it must be in MTT's best interests to remain in the UK in order to continue with his treatment and to remain relatively well. If he returns to Bangladesh he will face the possibility of early mortality and the certainty of limited and unpleasant medical treatment.

46. It is entirely understandable that it is the wish of his parents and of MTT himself that the family remains in the UK. We place particular weight on his wishes when assessing his best interests given that he is 14 years' old and that although we did not have evidence directly from him, he has made his view clear to a number of those around him.

47. In addition to his compromised health, we also accept that his educational development and life opportunities in the broader sense will be hampered by his removal, albeit he can be tutored and access modern media in his home. The quality of life that he has been able to develop in the UK because of his treatment and special educational support is of a much more significant depth and variety than that he had and will have on return to Bangladesh.

48. We also found that TZ's best interests really run in parallel to those of MTT. Her circumstances on return will be less stark than his. She will be with her parents and other relatives, has a relatively privileged background and will able to attend school, form friendships and so on. But where her brother's life in Bangladesh will be so difficult this can only but have a negative impact on all of the family, however assiduous the parents are in reducing the consequences for TZ. We accept that it is in her best interest to remain in the UK where her brother can be relatively well.

Proportionality

49. We have accepted that the best interests of both of the children here lie in remaining in the UK. That must remain a primary consideration in our assessment regardless of the other factors in play.

50. We have accepted above that the medical evidence shows that MTT could die without parenteral nutrition although no indication is given as to how reduced his life expectancy might be. As above, we could not avoid the fact that he lived in Bangladesh for 10 years playing a part in our thinking. What is certain is that his quality of life will be poor as only limited and unpleasant treatment will be available to him, significantly affecting his health and well-being.

51. The impact of MTT's compromised health and quality of life on his parent younger sister is also a significant factor.

52. We took into account also that even though they have been here lawfully, the family came with limited leave in order for RS to study not for MTT to receive medical treatment. There has never been a *de facto* commitment that MTT would be allowed to stay in the UK for medical treatment or leave granted for that purpose.

53. We are also required to apply the provisions of s. 117B. The family do not meet the requirements of the Immigration Rules and that weighs against them where the maintenance of effective immigration controls is in the public interest. The family speak English but that is not a factor that can weigh positively in their favour; see AM (S 117B) Malawi [2015] UKUT 0260 (IAC) and Forman.

54. We did not find that the family is financially independent given the reliance on public funds for MTT's medical and educational and special needs provision and also TZ's education. We have been given no figures but there must be a very significant burden on the taxpayer given the specialist treatment MTT is receiving and the support he receives at his special school. His parents are unable to pay for his medical treatment or education and are not paying for TZ's education. We accept that MTT and RS have otherwise been able to maintain the family by working lawfully, obtaining support from family members in Bangladesh and being accommodated by friends in the UK.

55. It is our view that the significant burden on the taxpayer now and in the future if the family remains in the UK is a significant factor weighing against them in the balancing exercise. As at [9] of AE:

> "Moreover, I do not consider that it would be inappropriate for the future cost and duration of [M]'s treatment and care in this country to play a part in the balancing exercise as matters relating to the economic wellbeing of this country, given the strains on the public finances."

56. Section 117B(5) mandates that little weight should be given to a private life that is established by a person at a time when the person's immigration status is precarious. The case of AM (S 117B) Malawi [2015] UKUT 0260 (IAC) states at paragraph 4 of the head note that:

> "Those who at any given date held a precarious immigration status must have held at that date an otherwise lawful grant of leave to enter or to remain. A person's immigration status is "precarious" if their continued presence in the UK will be dependent upon their obtaining a further grant of leave.

57. As above, it is undisputed that the family here have always been in the UK lawfully. The application for further leave that led to these proceedings

was made in-time and so the family's lawful student/dependent leave has been extended under section 3C of the Immigration Act 1971.

58. We were unsure whether it was correct to apply here the full force of the definition of "precarious" in AM. Following ZH, the immigration history of the family cannot be used to reduce the fixity of the weight that attracts to the best interests of MTT and TZ. We noted that ZH was decided prior to the introduction of s.117B, however.

59. It appeared to us that the position was as at [52] above, less weight attracting to the family's side of the balance where the family entered with limited leave and no expectation that any of the family could remain on medical grounds.

V. Conclusion

60. At the outset of MM, Moses LJ stated that it was "a sad and worrying case". We found this appeal to be so, also. However much sympathy we have for MTT, his sister and his parents, however, our judicial duty is to apply the law as we understand it to the facts as we find them to be.

61. We have endeavoured to set out above as clearly as possible our view of the law and our findings so that the family can at least know why we have reached the conclusion that we cannot allow the appeal.

62. No one factor played a definitive part in our decision. We kept in mind at all times the clarity of the children's best interests being in remaining in the UK. It remains the case that the evidence does not show that return to Bangladesh will definitely lead to a very reduced life expectancy. The medical evidence is that MTT's life "could" be in danger in Bangladesh without parenteral nutrition. The evidence is also that he survived in Bangladesh for 10 years, other than a short period in Singapore, before coming to the UK. We did not find that the facts here were sufficiently close to the high threshold required in a "medical" case, even where we are concerned with the futures of two children.

63. We know that MTT's life on return to Bangladesh will be very hard and unpleasant and that it will be difficult for his family where he is suffering. Against that, however, we are mandated to weigh the very significant burden to the taxpayer arising from MTT treatment and his and TZ's education.

64. In all the circumstances, we found that it was proportionate for MTT and his family to return to Bangladesh.

Decision:

We dismiss the Article 8 ECHR appeal.

Signed:  28 August 2015
Upper Tribunal Judge Pitt