IAC-AH-LEM-V1

Upper Tribunal
(Immigration and Asylum Chamber) Appeal Number: IA/25433/2011

THE IMMIGRATION ACTS

Heard at Bradford
On 6 May 2015

Decision & Reasons Promulgated
On 12 June 2015

Before

UPPER TRIBUNAL JUDGE CLIVE LANE

Between

RUTA ASEFAW
(ANONYMITY DIRECTION NOT MADE)

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:

For the Appellant: Mr S Knafler QC and Mr T Hussain, instructed by Parker Rhodes Hickmotts, Solicitors

For the Respondent: Mr M Diwnycz, a Senior Home Office Presenting Officer

DECISION AND REASONS

1. The appellant, Ruta Asefaw, was born on 28 June 1974 and is a female citizen of Eritrea. Following an initial hearing in the Upper Tribunal on 25 March 2013, I set aside the determination of the First-tier Tribunal promulgated on 14 June 2012 and adjourned the appeal to a resumed hearing in the Upper Tribunal at or following which I would remake the decision. My reasons for finding that the First-tier

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Tribunal made an error of law such that its decision fell to be set aside were as follows:

REASONS FOR FINDING THAT TRIBUNAL MADE AN ERROR OF LAW, SUCH THAT ITS DECISION FALLS TO BE SET ASIDE

1. The appellant, Ruta Asefaw, was born on 28 June 1974 and is a citizen of Eritrea. On 15 January 2008, the appellant was arrested having, in September 2007, presented a false Italian passport as evidence of entitlement to work. On 6 February 2008, she was convicted at Sheffield Crown Court of an offence relating to the false passport and sentenced to twelve months' imprisonment. On 11 June 2008, a decision was made to deport the appellant. The appellant appealed against that decision to the First-tier Tribunal (Designated Judge Dearden and Mr M E Fraenkel) which, in a determination promulgated on 14 June 2012, dismissed the appeal. The appellant now appeals, with permission, to the Upper Tribunal.

2. The First-tier Tribunal dismissed the appellant's asylum appeal and that part of the determination is not now challenged in the grounds of appeal to the Upper Tribunal. Those grounds concern the appellant's HIV positive medical condition only. I shall deal with the grounds in reverse order.

3. Ground 2 submits that the First-tier Tribunal failed to deal properly with the appellant's Article 8 ECHR appeal. The Tribunal, relying on **N (Application number 26565/05)**, found that the "majority" of the anti-retroviral drugs required by the appellant (and as detailed in a report from a Dr Gregg of the Sheffield Teaching Hospital's NHS Trust dated 19 January 2012) would be available to the appellant in Eritrea. At [35] the Tribunal noted that:

   > "The report from Dr Gregg observes that the appellant now takes abacavir, tenofovir, emtricitabine and darunavir, boosted with ritonavir. When one looks at A2 of the respondent's bundle one can immediately see that tenofovir and emtrictabine are available in Eritrea. One can see from B2 of the respondent's bundle that abacavir is available but darunavir and ritonavir are not. It is observed that a sub-optimal regime for the appellant would be combivir and lopinavir. According to the information from the respondents both are available in Eritrea."

4. The Tribunal went on to record that Dr Gregg had been concerned that the appellant would not have access to viral load monitoring and "therefore…failure to respond to treatment would not be detectable". The Tribunal noted that the background material indicated that HIV/AIDS treatment facilities are available to patients both as out and inpatients and that viral load test facilities were also available. Later at [35], the Tribunal concluded:

   > "In this case we conclude that medical treatment for HIV is available for the appellant in Eritrea. The exact combination of drugs may not be available to her but the majority of the drugs of which the appellant currently takes are available to her. This appellant is not critically ill or close to death and whilst we are sorry that she suffers from the HIV condition we decline to find that her case comes within the very exceptional circumstances as described in **N**. Whilst noting that the appellant says that she has no relatives in Eritrea we observe that she has previously, by several courts, been found to be an incredible witness. We do not accept that she is without relatives to turn to in Eritrea. On this basis, we decline to find that

returning the appellant to Eritrea would put the United Kingdom in breach of its obligations under Articles 3 and 8 because of the appellant's ill health."

5. Mr Hussein, in his oral submissions and the grounds of appeal relied on the Court of Appeal judgement in **DM Zambia [2009] EWCA Civ 474**, in particular [20]:

While, as I reiterate, we have not heard argument on this question, my tentative view is that this manifests a misunderstanding of what the Convention envisages when it speaks of private life and also of what it takes to engage Article 8. It is sufficient for the present to recall the holding of the European Court of Human Rights in S and Marper v UK (application nos. 30562/04 and 30566/04), to the effect that the House of Lords, Baroness Hale excepted, had erred in regarding the taking of DNA samples as not engaging Article 8 at all. One has to have clearly in mind that in Pretty v the United Kingdom (application no. 2346/02) the court found that private life included "the protection of physical and psychological integrity" and that in YF v Turkey (application no. 24209/94) they spoke again of private life including "the physical and psychological integrity of a person" and that "a person's body concerns the most intimate aspect of private life". Simply counting the number of friends that a person has in the United Kingdom is not how one establishes whether they have a private life. To remove an AIDS sufferer from free care and treatment in one of the best health services in the world, which had rescued her from what would otherwise have been a terminal condition, would have seemed to me, at least unless argument persuaded me otherwise, to have been a clear interference with her physical and psychological integrity and thus an invasion of her private life requiring justification.

6. Mr Hussein submitted that it had been wrong for the Tribunal to conflate the grounds of the appellant's appeal under Articles 3 and 8 ECHR since different considerations arose under each Article. The approach of the Tribunal appeared to be that, if the appellant could not succeed under Article 3, she must inevitably fail also under Article 8. However, Mr Hussein submitted, that approach ignored the comments of Sedley LJ in **DM** quoted above; the Tribunal had made no attempt to consider the effect upon the appellant's moral and physical integrity which would be caused by her removal to Eritrea.

7. Mrs Pettersen, for the respondent, acknowledged that the Tribunal may have erred by conflating Articles 3 and 8 in its analysis. She submitted that, had the Tribunal gone on to deal separately with Article 8, it would inevitably have found, in the light of its findings of fact, that the appellant's removal would be proportionate.

8. This appeal raises the difficult question of "medical" appeals that potentially engage the operation of both Article 3 and 8 ECHR. The Tribunal did deal with the appellant's private life in respect of Article 8 at [35] in the following terms.

> "In this case we have given the appellant the benefit of the doubt by finding that she does have a private life with her friends at the church, although we observe that she could have the same private life with church friends in Eritrea. In respect of private life therefore we find that the first three questions [of **Razgar**] should be answered 'yes'. However in conducting the necessary balancing exercise between the desire of the

appellant to remain in the United Kingdom and the desire of the United Kingdom government to have an orderly system of immigration control in the economic wellbeing of the country and for the prevention of disorder and crime we find that the balance comes down in favour of the United Kingdom government rather than the appellant. Any private life that has been built up by the appellant has been built up when she knew that she had no expectation that she would be allowed to remain in the United Kingdom indefinitely. We therefore find the Secretary of State's decision was proportionate."

9. Insofar as that analysis deals with aspects of the appellant's Article 8 private life other than her medical condition, the Tribunal has reached a conclusion which was clearly open to it on the evidence. Indeed, it is a conclusion which is not challenged by Mr Hussein whose focus has been entirely upon the appellant's HIV/AIDS condition. It is clear from the jurisprudence that, in particular circumstances, an appellant may succeed in a medical appeal under Article 8 where he or she fails under the more rigorous conditions required by Article 3. Mr Hussein submits that this is one of those rare cases and I consider that he may be correct. What is clear is that the Tribunal should have addressed the appellant's medical condition in the context of Article 8 but it failed to do so. For that reason, I find that its determination should be set aside. I have declined to proceed to remake the decision immediately; I consider that the Upper Tribunal would benefit from a further hearing at which new medical evidence may be adduced dealing *inter alia* with the observations which the First-tier Tribunal made regarding the sub-optimal drug regimes which may be available to the appellant in Eritrea (see above). I find that there is less merit in the appeal in respect of Article 3 ECHR in the light of the First-tier Tribunal's findings regarding alternative drug regimes which may be available (albeit sub-optimal and at a cost) to the appellant. However, given that I am adjourning the appeal for a resumed hearing, the Upper Tribunal will be prepared to hear argument and consider further evidence in respect of Mr Hussein's Article 3 ECHR submissions also. For the avoidance of doubt, the resumed hearing will be concerned only with the appellant's HIV/AIDS condition; the First-tier Tribunal's findings regarding her asylum appeal (and Article 3 ECHR insofar as that part of the appeal relates to the same particulars of the appellant's account as her asylum appeal) will not be revisited.

DECISION

The determination of the First-tier Tribunal promulgated on 14 June 2012 is set aside. The Upper Tribunal will remake the decision at or following a resumed hearing

2. At the resumed hearing at Bradford on 6 May 2015, Mr S Knafler QC and Mr T Hussain of Counsel appeared for the Appellant. Mr M Diwnycz, a Senior Home Office Presenting Officer, appeared for the respondent. I was grateful for the attendance of Dr Julia Greig. Dr Greig is a consultant physician/honorary senior clinical lecturer at Sheffield Teaching Hospitals. She has prepared a number of reports concerning the Appellant whom she has treated since 2008. Her many reports are contained in the appellant's bundle of documents at [18] *et seq*. The most recent report is dated 30 April 2015 but Dr Grieg's oral evidence primarily concerned her report of 12 September 2013 in which she has set out in detail the nature of the

treatment which the appellant requires and the likelihood of the appellant being able to access such treatment in Eritrea. The appellant has developed two mutations of the HIV virus, K65R and also G19E. The effect of the mutations is to render certain drug therapies ineffective in controlling her disease and minimising HIV viral load. At present the appellant takes, *inter alia*, Truvada, Avacivr and Darunavir and Ritonavir. Dr Greig explained that this combination of medication has controlled the appellant's HIV condition since the mutations in the virus were identified but, so far as she has been able to ascertain from discussions with drugs companies and other investigations, Truvada, Avacivr and Darunavir and Ritonavir are not marketed or available in Eritrea. Dr Greig said that the appellant would be likely, notwithstanding the mutations in the virus, to continue to live in the United Kingdom on her current regime of treatment for months and possibly years without serious difficulty. However, such HIV treatments which are available in Eritrea would not, on account of the mutations in the virus, prove effective. She said that one of the available drugs (Kaletra) appeared to be available in Eritrea only intermittently; in her report, Dr Greig noted that "patients who take HIV therapy intermittently do worse than those who take treatment continuously." She also explained that three of the drugs currently taken by the appellant form the "backbone" of her drug therapy; a "backbone" consisting of fewer than three drugs would simply be insufficient to suppress the appellant's viral load in the medium or longer term.

3. Mr Diwnycz, for the respondent, produced at court a response to a Country of Origin Information Request dated 27 June 2014. The request was brief: "I would like to know what treatments are available in Eritrea for HIV." The response, apparently based entirely upon information available on the MedCo database (a European Refugee Fund financed project to obtain medical country of origin information) indicted that medical professionals in Eritrea were available to treat those with HIV/AIDS both as outpatients and inpatients. In addition, laboratory CD4 counts are available together with viral load testing facilities. The report went on to say "in addition, the following ARV drugs are available in Eritrea: Atripla; Tenofovir; Entricitabile; Efavirenz." Dr Greig was shown the document and made two comments. First, the mutations in the appellant's HIV virus would mean that the drugs listed would be wholly ineffective. Secondly, she said that she was very surprised if count facilities and, indeed, regular treatment by doctors would be available outside private hospitals.

4. I shall deal at this point with the document produced by Mr Diwnycz. Mr Knafler submitted that the response document listed fewer drugs than evidence submitted previously (including the Country of Origin Information Report for Eritrea) had indicated would be available. He submitted that the situation of treatment of HIV in Eritrea had, therefore, markedly deteriorated. Whilst I note that submission, I consider that the response document needs to be treated with considerable caution. First, it is brief being based only on one source. Secondly, there was nothing in the document to indicate that its contents supersede details available in the existing COI Report. Thirdly, there is nothing in the response to suggest that the list of four drugs is exclusive and that no other drugs are available. Consequently, I do not accept that,

for the purposes of my analysis, I should assume that the only drugs available for HIV in Eritrea are the four drugs listed in the response document.

5. It would appear from Dr Greig's oral and written evidence the following conclusions may be drawn. First, the appellant is currently in relatively good health on a stable drug regime notwithstanding the mutations in her virus which have rendered certain drug therapies ineffective. Secondly, drugs are available in Eritrea to treat HIV albeit that treatment on a regular basis may only be obtained in private hospitals. Mutations in the appellant's virus appear to have made it much less likely that a sufficient number of effective drugs would be available to form the "backbone" of the appellant's treatment and to stabilise her viral load in the longer term. Whilst it cannot be said that there is a total absence of treatment available in Eritrea there is very likely to be a lack of regular treatment available to treat the appellant's mutated HIV virus. Finally, in response to questions regarding the four drugs referred to in the response document, Dr Greig said that the appellant would be likely to die within two years of return to Eritrea if those drugs and no others were available to her. Death would be likely to occur as a result of the appellant being unable to fight off opportunistic and aggressive infections and viruses.

6. It was against this medical background that Mr Knafler made his submissions. I was also assisted by the very helpful skeleton argument prepared by Mr Knafler together with Mr Hussian and Mr Cole of Parker, Rhodes Hickmotts. Mr Knafler's submissions were divided into two categories which I shall also adopt, namely Article 3 ECHR and Article 8 ECHR.

<u>Article 3 ECHR</u>

7. The appellant argues that she would face inhuman or degrading treatment upon return to Eritrea on account of the fact that she would be viewed as a failed asylum seeker and, as a consequence, be detained without medical care. The COI Report of 18 September 2013 at 28.15 states:

> 'Testimonies of returned asylum seekers indicate that the act of claiming asylum is perceived by the authorities as involving a criticism of the government and – as with all other forms of dissent – is therefore not tolerated. Forcibly-returned asylum seekers interviewed by Amnesty International were tortured both as a form of punishment for perceived criticism of the government and for the purposes of interrogation. According to accounts given by escaped detainees, Eritrean security officials are particularly interested in how asylum seekers fled the country, who assisted them and what they said against the Eritrean government during their asylum application process. Returnees have reported that under torture or threat of torture, they were forced to state that they have committed treason by falsely claiming persecution in asylum applications.'

8. Significantly in the case of the present appellant, the parties agree that she left Eritrea legally and on her own valid passport. Given the length of time that the appellant has been in the United Kingdom, it is possible that passport has now expired but I had no evidence to show that that was the case or, if it has expired, that the appellant had taken any steps to renew the passport. How the appellant "fled the country" is

therefore not a factor in her case. In addition, country guidance on this matter has not altered since November 2006 when *AH (Failed asylum seekers – involuntary returns) Eritrea CG* [2006] UKAIT 00078 was promulgated by the Asylum and Immigration Tribunal. That Tribunal concluded that "neither involuntary returnees nor failed asylum seekers are as such at real risk on return to Eritrea." *AH* appears on the list of extant country guidance cases which was updated on 18 February 2015. I acknowledge that the evidence upon which the appellant relies postdates *AH*. I note that the UNHCR Special Rapporteur writing in May 2013 considered that "the forced and supposedly voluntary return of Eritrean citizens to their country … despite warning from UNCHR and other international organisations is of grave concern." However, in my opinion there is simply insufficient evidence before the Upper Tribunal for it to conclude that a failed asylum seeker who was forcibly returned to Eritrea but who has not left that country unlawfully may be able to return in possession of a valid passport faces a real risk of being detained and tortured on arrival. Insofar as the appellant relies on Article 3 ECHR for reasons unconnected with her medical condition, I reject her claim that she faces a real risk of inhuman or degrading treatment. In reaching that finding I am reminded that the First-tier Tribunal rejected the appellant's claim for asylum and that a previous Tribunal as long ago as December 2003 found that, because the appellant had previously possessed a national passport, she would be able to obtain a travel document from the Eritrean embassy. It is also significant that not only did the appellant travel to the United Kingdom on her own passport but was granted leave to enter initially as a domestic worker, the same status which she had enjoyed upon entry to Saudi Arabia, the country to which she had travelled directly from Eritrea in February 2002.

9. Mr Knafler's next submission brought the appellant's medical condition into the analysis. He submitted that the appellant was likely, upon entering Eritrea, to be detained for a period of time during which she would not have access to her HIV medication. In that period of detention, the appellant might become prey to opportunist infections which might make her ill or even kill her whilst in the extremely poor prison conditions for which Eritrea is notorious.

10. I am not persuaded by that submission. First, the evidence (in particular, the COI Report of September 2013) gives no clear indication of the likely length of any possible detention. The report notes that "in each case reported to Amnesty International the arrest took place immediately upon arrival of the individual in Eritrea. Periods of detention reported to Amnesty International range from a number of days to a number of years." More significantly, as I have found above the appellant will be able to show that she left Eritrea to work abroad as a domestic worker and did so on a valid passport. Although she is being deported to Eritrea, it is likely that she will be able to obtain a valid travel document if her own passport has expired. I am not persuaded that she would be treated as a rejected asylum seeker or potential traitor by the receiving Eritrean authorities. Secondly, even if she were to be detained it is not, in my opinion, likely that she would be regarded as a significant threat by the Eritrean authorities and that, insofar as any estimate can be given on such paltry evidence, it is likely that her detention would last for days rather than weeks or months. Although the matter was not discussed with Dr Greig

nor is it referred to in the written evidence, I can see no reason why the appellant's doctors, knowing that the appellant would imminently return to Eritrea, would not provide her with a course of her current drug regime for as long a period as possible given the likelihood that drugs may be difficult to find in Eritrea. I do not find, on the evidence, that, even if she were detained, the appellant would be prevented from taking any drugs which she had brought with her from the United Kingdom. I do find that she would be likely to emerge from detention (if it occurred at all) having been able to maintain her current drug regime throughout the period of detention. She would not, as a result, be susceptible to the opportunist infections which might harm her.

11. Mr Knafler also relied on the COI Report and other evidence to which I have already referred (the UNHCR Report) which indicates that the authorities significantly restrain internal travel in Eritrea. That evidence is supported by letter from the British embassy in Asmara dated 10 August 2010 which indicates that "travel permits are required to travel anywhere in Eritrea, travel to border areas is not permitted." Only those who have completed their national service are likely to be able to travel within the country. The appellant's skeleton argument asserts that it would be "highly unlikely that the appellant would be able to travel to access medical treatment even if available for her specific strain of HIV."

12. The problem with the appellant's argument is that there is no obvious causal link between possible restrictions on her ability to travel within Eritrea and her ability to access drugs required for HIV treatment. The appellant is likely to return to Asmara where it is likely most private and other medical facilities are situated. If she remains there, she is likely to have the best chance of accessing the drugs and treatment she requires. There is no evidence to suggest that drugs or treatment may be obtained elsewhere in Eritrea or that those drugs and treatments might potentially assist her if, but for the restrictions on travel, she were able to access them.

13. It is also important to bear in mind that health cases have particular considerations in the context of Article 3 ECHR. All such cases should be considered in the light of *N* [2005] 2AC 296 and *D v United Kingdom* 24 EHRR 423. The Court of Appeal in *ZT* [2005] EWCA Civ 1421 reiterated this fact at [16]:

> "The argument, as a point of law, is misconceived. *Soering* came nowhere near to laying down any special rule about the behaviour of the receiving state, within the ambit of the single rule of article 3 in terms of inhuman and degrading treatment. What the Strasbourg court did hold, in its paragraphs 104-111, was that if there was a prospect of the "death row phenomenon" being unduly extended in a particular case, then it would be a breach of the basic rule of article 3 to return the prisoner to suffer that fate. The prisoner's suffering would, indeed, be caused by the laws and procedures of the receiving state, but that was simply a matter of the factual history creating the condition that the sending state must avoid, and not the reason why article 3 was held to have been breached. Article 3 was breached in that case because, applying the general regime of article 3, a defined and plainly unjustified state of suffering awaited the returned prisoner. But in the particular factual category of health cases, *N* lays down the rules as to how article 3 should be applied. Those rules include a specific requirement of exceptional circumstances. They do not include a special sub-category,

turning on the behaviour of the receiving state, that takes the case outside the normal article 3 regime."

14. The court in *ZT* went on at [18] to observe;

> "That said, I can envisage a case in which the particular treatment afforded to an AIDS sufferer on return, in terms of ostracism, humiliation, or deprivation of basic rights that was added to her existing medical difficulties, could create an exceptional case in terms of the guidance given by Baroness Hale of Richmond, cited in paragraph 12 above. That would, in the first instance, be a matter for the Secretary of State. In the present case the evidence before the IAT came nowhere near to supporting such a contention; indeed, the IAT adopted evidence from the then current CIPU report which, although making very grim reading, did not paint a picture as alarming as that contended for by the appellants in late 2005. I revert to this aspect of the case at the end of this judgment."

I am not satisfied that "the specific requirement of exceptional circumstances" has been made out in the present case. I am aware that the existing country guidance is rather old, it has, significantly, not been replaced whilst the evidence which has been adduced does not, in my opinion, render it reasonably likely that an individual having the particular characteristics or travel history of this appellant would face Article 3 ECHR conditions either directly at the hands of the Eritrean authorities or as a combination of her treatment by those authorities and her medical condition.

Article 8 ECHR

15. The law concerning "medical" Article 8 ECHR cases has recently been clarified by the Court of Appeal in *GS (India)* [2015] EWCA Civ 40. Giving the leading judgment, Laws LJ stated at [85 – 87]:

> "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. That approach was, as it seems

to me, applied by Moses LJ (with whom McFarlane LJ and the Master of the Rolls agreed) in *MM (Zimbabwe)* [2012] EWCA Civ 279 at paragraph 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."

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:

> "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." "

16. Agreeing with Laws LJ, Underhill LJ consideredthat the starting point should remain *Razgar* [2004] UKHL 27 where the House of Lords considered that "a decision to remove a person from the United Kingdom where that would prejudice his or her access to medical treatment may in principle engage Article 8" {108]. However, Underhill LJ went on to observe at [110]:

> "However, that raises the question of how, if article 8 is indeed potentially engaged in cases of this kind, that is reconcilable with the principle established in relation to article 3 that a member state is under no obligation to permit a person to remain for the purpose of obtaining medical treatment not available in the country of return. In enunciating that principle in *N* neither the House of Lords nor the Strasbourg Court reviewed its relationship with the potential engagement of article 8 as established in *Bensaid* or *Razgar*: that is indeed one of the criticisms made in the judgment of the minority in Strasbourg in *N* – see para. O-I26 (pp. 911-2)."

17. He then considered the "no obligation to treat" principle enunciated in *MM (Zimbabwe)* [2014] EWCA Civ 985:

> "It is that question which this Court addressed in *MM (Zimbabwe)*. Moses LJ, with whom the other members of the Court agreed, held that the "no obligation to treat"

principle must apply equally in the context of article 8: see paras. 17-18 of his judgment, which Laws LJ sets out at para. 89 above. He then sought to identify what role that left for article 8. He acknowledged that "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", referring to *Razgar* and also to *AJ (Liberia) v Secretary of State for the Home Department* [2006] EWCA Civ 1736 (another mental health case); but he drew attention to statements in both cases emphasising how exceptional the circumstances would have to be before a breach were established. In particular, he set out, at para. 20, a passage to that effect from the opinion of Lady Hale in *Razgar* which starts with the observation that "it is not easy to think of a foreign health care case which would fail under Article 3 but succeed under Article 8". He concluded, at para. 23 with a passage which Laws LJ has already quoted but which for ease of reference I will set out again:

> "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."

There are possibly some ambiguities in the details of the reasoning in that passage, but I think it is clear that 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."

18. In the present case, there appears to be no doubt that the treatment which the appellant requires is "life preserving"; the evidence of Dr Greig makes that plain. As regards the basis upon which the appellant may bring a claim under Article 8, she has no family living in the United Kingdom but has plainly developed a private life here (as is evidenced by the support she has received from members of her church and community). The difficulty in accessing consistent medical treatment in Eritrea may, therefore, be a factor in the proportionality exercise but it may not dominate that exercise in such a way as to contravene the "no obligation to treat" principle. It is trite to observe the judgements of the senior courts are important for the principles of law which they contain rather than because their factual matrices may resemble those in other cases. Having said that, the circumstances of the current appellant are not dissimilar from those of the appellant PL in *GS (India)* whose appeal Underhill LJ considered at [114]:

> "As for PL, if one leaves aside the issue of the unlikelihood of his receiving access to proper treatment in Jamaica, his claim under article 8 is hopeless. It is true that he has been in the United Kingdom since 2001 and has formed friendships here, principally through his church. It was apparently on that basis that the Judge in the First-tier Tribunal, addressing the first two of the conventional "*Razgar* questions", held that his removal would interfere with his right to respect for his private life, and to a degree which potentially engaged article 8. But for almost all of that period he has been here illegally: he was given leave to enter only as a visitor and has been unlawfully over-staying since November 2002. He made an asylum claim for the first time in 2012 which the Judge found to have no merit. He has no family ties in this country. The Judge rightly held that his friendships were formed in the knowledge that he had no right to remain and that they could not have significant weight in the balance against the legitimate interests of immigration control. In those circumstances, to strike the article 8 balance in his favour only because of the consequences for his health if he were removed, however grave, would be in substance to impose an obligation to treat."

19. I have no doubt that the appellant has a strong private life in the United Kingdom with friends at church and in her wider community. The appellant had become appeal rights exhausted in January 2004 and, although she made an application for discretionary leave in 2007 (which was refused) she remained in the United Kingdom unlawfully and, indeed, committed a criminal offence here for which she was sentenced to twelve months' imprisonment. If one were to leave aside the "unlikelihood of her receiving access to proper treatment" in Eritrea her private life Article 8 claim, like that of the appellant PL, would have to be considered as "hopeless." She has formed her friendships and ties in the United Kingdom in the full knowledge that she had no right to remain here. Following the authority of the Court of Appeal in *GS*, I am unable to conclude that it is correct in law to tip the Article 8 balance in the appellant's favour simply on account of the consequences for her health if she were to be removed to Eritrea, "however grave" those consequences may be. I find that, if I were to allow the appeal on that basis, I would, in the light of the appellant's offending, the public interest concerned with her removal and the fact that she has developed a private life in this country knowing that she had no right to be here, would, in effect, contravene the "obligation to treat" principle. I must find, on the basis of the authorities but without any enthusiasm, that the appellant cannot succeed in her appeal on Article 8 ECHR grounds.

<u>Notice of Decision</u>

The appellant's appeal against the respondent's decision dated 19 August 2011 is dismissed.

No anonymity direction is made.

Signed Date 10 June 2015

Upper Tribunal Judge Clive Lane

I have dismissed the appeal and therefore there can be no fee award.

Signed   Date 10 June 2015

Upper Tribunal Judge Clive Lane