IN THE UPPER TRIBUNAL
IMMIGRATION AND ASYLUM CHAMBER

Case No: UI-2023-004866

First-tier Tribunal No: PA/50234/2023

THE IMMIGRATION ACTS

Decision & Reasons Issued:

10th January 2024

Before

UPPER TRIBUNAL JUDGE NORTON-TAYLOR
DEPUTY UPPER TRIBUNAL JUDGE FROOM

Between

The Secretary of State for the Home Department

Appellant

and

JHRB
(ANONYMITY ORDER MADE)

Respondent

Representation:
For the Appellant: Mr E. Terrell, Senior Home Office Presenting Officer
For the Respondent: Mr S. Coburn, Legal Representative

Heard at Field House on 21 December 2023

Order Regarding Anonymity

Pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008, JHRB is granted anonymity.

No-one shall publish or reveal any information, including the name or address of JHRB, likely to lead members of the public to identify JHRB. Failure to comply with this order could amount to a contempt of court.

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DECISION AND REASONS

1. The Secretary of State appeals with the permission of the First-tier Tribunal against a decision, dated 1 November 2023, of Judge of the First-tier Tribunal M J Fisher ("the judge") allowing the appeal brought by JHRB, a citizen of Iraq on the ground that removing him would breach the United Kingdom's obligations under Article 3 of the Human Rights Convention. JHRB had brought his appeal against a decision of the Secretary of State, dated 4 January 2023, refusing his protection and human rights claims. The judge dismissed the appeal on protection grounds but allowed it on Article 3 health grounds. JHRB has not brought a cross-appeal against the judge's decision on his protection claim.

2. Although the appellant is the Secretary of State in this appeal, it is more convenient to refer to the parties as they were before the First-tier Tribunal. We shall therefore refer in this decision to JHRB as "the appellant" and to the Secretary of State as "the respondent".

3. The First-tier Tribunal made an anonymity order because the appeal involves protection issues and sensitive medical information concerning the appellant. No submissions were made to us to lift the order, which is maintained.

The factual background

4. The appellant's immigration history does not require detailed expression in this decision given the narrow issue which is now before the Upper Tribunal. Suffice it to say the appellant is accepted as being a citizen of Iraq. He arrived in the United Kingdom most recently on 20 December 2017 and he claimed asylum on 12 February 2020. Since around that time the appellant has been under treatment for a severe lung condition.

5. In a decision dated 4 January 2023 the respondent rejected the appellant's claims. Under the heading Discretionary Leave, the respondent considered and rejected the appellant's Article 3 claim on medical grounds. The appellant had stated at his screening and substantive asylum interviews that he had received treatment for his condition in Iraq. The evidence he had provided did not indicate that treatment was unavailable or that he would lack access to such treatment in Iraq or that there were substantial grounds for believing that he would face a real risk of being exposed to a serious rapid and irreversible decline in his state of health resulting in intense suffering or a significant reduction in life expectancy. The letter listed some healthcare facilities in Iraq.

6. Dr A, a consultant respiratory physician, wrote to the appellant's GP after examining the appellant on 5 April 2023. The diagnosis and past medical history are noted as primary ciliary dyskinesia, very severe airflow obstruction, chronic rhinosinusitis, mild nasal polyps, intolerant of

nebulised Colomycin, positive aspergillus serology and raised total serum IgE, mild prolongation of QTc interval and right bundle branch block, osteoporosis, anxiety, depression and poor sleep pattern, severe vitamin D deficiency, small liver haemangiomas, coeliac disease and QuantiFERON TB Gold test negative. On examination, the appellant reported a significant reduction in sputum purulence and volume since a course of intravenous antibiotic therapy and an improvement in the level of breathlessness. However he continued to use ambulatory oxygen therapy most days.

7. In a letter addressed "to whom it may concern", dated 6 April 2023, Dr A wrote that the appellant had,

> "… been under the care of the Adult Bronchiectasis Team for over three years and due to the multiple, complex and severe underlying lung conditions will require specialist care indefinitely … Care would include a specialist subcutaneous line to administer regular intravenous antibiotic therapy …, ear, nose and throat intervention/surgery and oxygen therapy which he is currently on. There is also the possibility that he may require lung transplantation in the near future should the lung conditions continue to deteriorate or progress which is the most likely scenario.
>
> To the best of my knowledge, specialist care for the rare medical condition of PCD isn't available in Iraq … Survival in a country without specialist care, based on available information from multiple investigations so far, would be less than five years".

8. The appellant also provided a letter from Dr AA, a general surgeon practising in Iraq, dated 12 July 2023. The letter stated that the appellant's complaints of coeliac disease and lung fibrosis required continuous treatment, which is specialised and costly in Iraq. Furthermore, the hot and dusty conditions in Iraq were not compatible with his life.

9. In support of his appeal to the First-tier Tribunal the appellant relied on the Country Policy and Information Note ("CPIN") Iraq: Medical and healthcare provision, dated January 2021. This noted the report of the World Bank Group, dated February 2017, which stated that access to health services was limited and geographical disparities were significant. Primary health centres and public hospitals were low-cost but poor organisation and shortages of staff and medications were significant impediments to delivering adequate services.

10. The appellant gave evidence at his appeal hearing in the First-Tier Tribunal and was represented by Mr Coburn.

The judge's decision

11. As said, the judge rejected the appellant's protection claim and he concluded he had fabricated an account for asylum to assist him to remain in the United Kingdom on health grounds. He observed that Mr Coburn's closing submissions were largely focussed on the discrete Article 3 claim.

He noted the medical evidence, including the letters of Dr A, dated 6 April 2023. The judge attempted to narrow the issues with the respondent's representative, Ms Foster. She said the appellant had received treatment previously in Iraq and she submitted treatment would be available to the appellant albeit it would be expensive. She also submitted, presumably in the alternative, that a five-year timescale was not evidence of a rapid and irreversible decline in health which would meet the Article 3 threshold.

12. In view of the fact Mr Terrell's attack on the judge's reasoning involved close textual analysis, it is necessary to set out the whole of the judge's reasoning:

> "21. I have considered the decision in AM (Zimbabwe) v SSHD [2020] UKSC 17. It is for the Appellant to adduce evidence capable of demonstrating that there are substantial grounds for believing that, if removed from the UK, he would be exposed to a real risk of ill-treatment which would cross the Article 3 threshold, specifically, of being exposed to either a serious, rapid and irreversible decline in health resulting in intense suffering, or a significant(substantial) reduction in life expectancy. Where such evidence is adduced, itis for the state to dispel serious doubts raised by it, verifying whether the care generally available in Iraq is, in practice, sufficient to prevent exposure to treatment contrary to Article 3. It also has to consider the accessibility of the treatment, having regard to its cost, the existence of a family network and its geographical location. If serious doubts continue to surround the impact of removal, the UK authorities must obtain an individual assurance from Iraq that appropriate treatment will be available and accessible to the Appellant.
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> 22. The closing submissions made by Ms Foster on the Article 3 health claim were limited to reminding me of the high threshold imposed, a suggestion that the medical evidence provided was "inadequate", and that the burden of proof rested with the Appellant. I was directed to the decision letter concerning medical facilities in Iraq and the presence of the doctor in Iraq. I was invited to find that medication was available. Mr Coburn's response was to direct me to paragraph 1.1.2 of the January 2021 CPIN and pages 5 to 12 of the Appellant's bundle. The CPIN highlights a report produced by the World Bank Group in February 2017 which stated "Access to health services is limited, and geographical disparities are significant. In the public sector, health services are provided through a network of primary health care centers (PHCC) and public hospitals at very low charges. The PHCCs provide preventive and basic curative services. The main centers are located in urban areas with smaller centers in rural areas. Poor organization and shortages of staff and medications are significant impediments to delivering adequate services in the PHCCs. Despite this, the PHCCs are recognized as very important sources of healthcare provision, particularly for the poor."
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> 23. The next paragraph of the report, not cited before me, is perhaps more relevant to this Appellant. It states "For secondary and tertiary care, patients are referred from PHCCs to hospitals, although it is estimated that only about40 percent of Iraqis have access to these referral services because of the inadequate number and uneven distribution of public

hospitals. Secondary and tertiary care are also provided by small private hospitals. Since there are no health insurance schemes in Iraq, the costs of private health care must be met out-of-pocket, which is well beyond the reach of many Iraqis...Most of the health sector in Iraq is financed by the government with a small but growing private sector financed by out-of-pocket payments from patients."

24. I had regard to paragraph 19.2 of the CPIN which relates to pulmonology conditions other than TB. The information contained therein is taken from the MedCOI website. It lists some examples of hospitals and clinics which treat pulmonary conditions and pharmacies/clinics which can provide appropriate medication. It states that inpatient treatment by a pulmonologist is available at the Baghdad Teaching Hospital, which is a public facility, as well as in two hospitals in Sulaymaniyah and Erbil. Outpatient treatment and follow up from a pulmonologist is available at two private facilities in Baghdad, as well as in one private facility in Sulaymaniyah and one in Erbil. Diagnostic research, in the form of lung function tests, is available in a private facility in Baghdad, and oxygen therapy, with a device and nasal catheter similar to that used by the Appellant, is available in a private facility in Sulaymaniyah. None of this evidence covers the specific and complex diagnosis set out by [Dr A].

25. It is undoubtedly the case that the Appellant's representatives could have provided more evidence in this appeal. They could have arranged for [Dr A] to give oral evidence, and they could have obtained a country expert's report on the availability and cost of treatment in Iraq.

26. I note from paragraphs 11 to 13 of the Appellant's witness statement that he admits that he had to take medication in Iraq, but that his condition has deteriorated in the UK. That deterioration is consistent with the evidence from [Dr A], and I accept that his health is worse, and likely to decline further. The Appellant was not challenged on that deterioration in cross examination. Similarly, he was not challenged on his assertion that his father had paid for his medication in Iraq, but that he had since passed away. Cross examination on the health issues was limited to asking the Appellant whether [Dr AA], whose letter appeared at page 9 of his bundle, was in Iraq or the UK. The Appellant replied that he was in the former. He was not asked about the circumstances in which this letter was obtained or even whether [Dr AA] had treated him. The letter does not confirm this, merely referring to "seeing the reports of the patient".

27. Despite the fact that greater evidence could have been adduced, it is clear to me that the Appellant requires highly specialist care for extremely serious health issues. I am not satisfied that adequate treatment would be available in Iraq. His return would expose him to a real risk of the breach of Article 3 on health grounds. It is for the Respondent to dispel the serious doubts about it, and to show that appropriate treatment would be available to him in Iraq. She has singularly failed to do so. The consideration given in the refusal letter is cursory and generalised. It refers to a whether a grant of discretionary leave would be appropriate and does not deal with the Article 3 claim in appropriate detail. Ms Foster apparently failed to appreciate that there is a burden on the Respondent to demonstrate that adequate care would be available in Iraq. Consequently, I accept [Dr A]'s evidence that survival for this Appellant would be less than five years. I also remind myself

> of his evidence that the Appellant may require lung transplantation "in the near future" should his lung conditions continue to deteriorate or progress, as is the most likely scenario. There was no individual assurance about treatment as envisaged in the caselaw.
>
> 28. The Appellant is a 40 year old man. Survival for less than five years in the absence of specialist care would amount to a substantial reduction in his life expectancy. Again, Ms Foster failed to address me on that facet of the criteria. In all of the circumstances, I find that the Article 3 claim is made out on health grounds."

The issues on appeal to the Upper Tribunal

13. The grounds seeking permission to appeal made two points. Firstly, the judge arguably failed to properly apply the burden of proof. The judge held at [27] that he was not satisfied that adequate treatment would be available in Iraq but at [25] he had observed that the appellant's representatives could have provided more evidence, such as a country expert report on the availability and cost of treatment in Iraq. The appellant was not asked whether Dr AA had treated him in Iraq and the judge had removed the burden of proof from the appellant or significantly diluted it. Reliance was placed on THTN v SSHD [2023] EWCA Civ 1222, at [48], and AM (Zimbabwe), at [32].

14. Secondly the grounds argued the judge had materially erred in his application of the law. It was arguable the judge had applied too lax a test when finding that survival for less than five years in the absence of specialist care would amount to a substantial reduction in life expectancy. Given the length of the timescale it was arguable there was no causal link between removal and the treatment said to breach Article 3.

15. Judge of the First-tier Tribunal I D Boyes granted permission to appeal on both grounds.

16. No rule 24 response has been filed.

17. As should by now be familiar to all practitioners in this jurisdiction, new standard directions have been issued by the Upper Tribunal as of 25 September 2023. The core aspect of these directions is to require the party appealing to the Upper Tribunal to provide a composite bundle containing specified materials and in a proper format. The respondent has filed a composite bundle but has done so extremely late. Mr Terrell apologised and explained that, having become aware of the issue only two days before the hearing, he had made it a priority that the bundle be prepared and uploaded. In the circumstances, we take no further action other than to take this opportunity to remind the parties of the importance of prompt compliance with directions.

18. The composite bundle runs to 506 pages.

The submissions

19. Mr Terrell relied on both the grounds submitted, but focused on the first. His challenge did not include any perversity or rationality argument.

20. In relation to the first ground, Mr Terrell argued the judge had failed to appreciate that there was a burden on the appellant to make out a prima facie case that there would not be treatment available in Iraq before the burden switched to the respondent to dispel any doubts. He argued the judge had started with the burden on the respondent. Apart from that, he accepted the judge's self-direction at [21] was correct. The judge's analysis of the background evidence did not show the existence of "strong evidence" sufficient to place a burden on the respondent. In relation to the second ground, Mr Terrell agreed that Lord Wilson had not been setting a two-year threshold test at [31] of AM (Zimbabwe) and he made clear that the context was important.

21. Mr Coburn, who appeared remotely, argued there is no error in the judge's decision. The judge had found the appellant would not be able to access adequate treatment based on his evidence. The two-stage process described in AM (Zimbabwe), at [33], had been followed. There was significant evidence that the appellant's life expectancy would be reduced.

22. Mr Terrell did not wish to reply. Having heard full submissions we reserved our decision.

The law

23. The jurisdiction of the Upper Tribunal on an appeal from the First-tier Tribunal lies only in relation to an error of law, not a disagreement of fact. The following are possible categories of error of law, as summarised in R (Iran) & Ors v SSHD [2005] EWCA Civ 982 at [9]:

> "i) Making perverse or irrational findings on a matter or matters that were material to the outcome ("material matters");
>
> ii) Failing to give reasons or any adequate reasons for findings on material matters;
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> iii) Failing to take into account and/or resolve conflicts of fact or opinion on material matters;
>
> iv) Giving weight to immaterial matters;
>
> v) Making a material misdirection of law on any material matter;

> vi) Committing or permitting a procedural or other irregularity capable of making a material difference to the outcome or the fairness of the proceedings;
>
> vii) Making a mistake as to a material fact which could be established by objective and uncontentious evidence, where the appellant and/or his advisers were not responsible for the mistake, and where unfairness resulted from the fact that a mistake was made."

24. It is important, as has been repeatedly emphasised in many authorities, not to construe disagreements of fact as errors of law. See, for example, the Presidential Panel in Joseph (permission to appeal requirements) [2022] UKUT 218 (IAC) at [13].

25. The correct approach to the burden of proof in Article 3 health claims, with particular emphasis on the issue of availability and accessibility of treatment, has recently been clarified in THTN. William Davis LJ, with whom Peter Jackson and Nicola Davies LJJ agreed, stated:

> "48. In my judgment the true position falls between these two extremes. As was explained at [186] of *Paposhvili* "it is not a matter of requiring the persons concerned to provide clear proof of their claim that they would be exposed to proscribed treatment". Rather, the applicant must "adduce evidence capable of demonstrating that there are substantial grounds for believing that, if the measure complained of were to be implemented, they would be exposed to a real risk of being subjected to treatment contrary to Article 3". This is not a position which will lead to uncertainty as submitted explicitly by Mr Jafferji and implicitly by the SSHD. Stage one of the process requires the applicant to provide strong evidence of the seriousness of the illness including the treatment involved and the consequences of removal of treatment. Those are matters which will only be within the knowledge of the applicant. She also must provide sufficient evidence to cast doubt on the availability or accessibility of treatment in the receiving state. The SSHD (or on appeal the F-TT) will be well capable of determining whether sufficient evidence has been adduced to cast doubt on the receiving state's medical facilities. This is reflected in the discussion at [32] in *AM (Zimbabwe).* The passage at [33] on which Mr Jafferji relied must be read in that context.
>
> 49. In *AM (Zimbabwe)* the Supreme Court anticipated that *Savran* would shed light on the procedural requirements. I am satisfied that *Savran* confirmed the position. The threshold test set out at [134] clearly requires evidence from the applicant about the position in the receiving state before there is any obligation on the returning state. The Strasbourg court does not use the term prima facie case since that is not a concept commonly in use at that court. However, it is the term used by Sales LJ (as he then was) in the Court of Appeal in *AM (Zimbabwe)*. It is a concept familiar in this jurisdiction and more than capable of being applied in relation to applications of this kind."

(emphasis added)

The judge's approach to the medical evidence

26. Having carefully considered the oral submissions made to us, the relevant parts of the judge's decision and the evidence relied on by the parties, we have concluded that neither of the grounds relied on by the responded is made out. The judge's self-direction and application of the law are sustainable and not vitiated by any material errors of law. It follows that the respondent's appeal must be dismissed and the First-tier Tribunal's decision to allow the appellant's appeal on Article 3 grounds (but dismissing it on all other grounds) shall stand. Our reasons, dealing with the grounds in turn, are as follows.

27. At [21] the judge set out his self-direction and stated he had done so after consulting the Supreme Court's judgment in AM (Zimbabwe). Mr Terrell was good enough to agree that this self-direction is correct as far as it goes. However, he argued it did not make plain that part of the appellant's burden included the need to show "strong evidence", not only that he suffered from a serious illness and that the consequences of not receiving treatment would be sufficiently serious, but also that he would not be able to access adequate treatment in Iraq. In fact, submitted Mr Terrell, the decision shows that the judge had placed the burden of showing the absence of adequate medical treatment exclusively on the respondent.

28. Had the judge adopted the approach Mr Terrell suggests, his approach would clearly have been unsafe. However, we do not agree that a fair reading of the decision as a whole supports Mr Terrell's argument.

29. It is true that the judge began his analysis at [19] by referring to his invitation to Ms Foster, the presenting officer, to present medical evidence. He continued at [22] to imply that he was unimpressed by Ms Foster's closing submission in which she had stated the burden of proof was on the appellant. At [25] the judge pointed out how much more the appellant could have done to discharge the burden on him.

30. Insofar as the appellant relied on Dr A's letter in order to establish the absence of treatment in Iraq, the judge had recorded at [19] the self-evidently correct submission made by Ms Foster that Dr A was not a country expert. However, the judge does not appear to rely on the part of Dr A's letter which states there is no suitable treatment for the appellant in Iraq. The letter from Dr AA is very short and adds little, given that his knowledge of the appellant and expertise in the area of respiratory medicine are far from clear. However, the judge does not appear to have placed weight on it.

31. Following on from his correct self-direction at [21], the judge assessed the availability of treatment by reference to the CPIN, which was cited in the appeal skeleton argument prepared on behalf of the appellant. In short, access to health services was limited and poor organisation and shortage of staff and medication are impediments to delivering adequate

services. He then noted at [23] further passages from the CPIN which stated that it was estimated that only 40% of Iraqis had access to secondary and tertiary care because of the inadequate number and uneven distribution of public hospitals. Specialist treatment was available privately but this was well beyond the reach of many Iraqis. At [24] the judge noted the passages from the CPIN relating to pulmonary conditions other than TB. However, none of the evidence covered the specific and complex diagnosis set out by Dr A.

32. In our judgment, it was entirely open to the judge to rely on these passages from the CPIN to cast doubt on the availability or accessibility of treatment in the receiving state. It certainly was the case that the appellant could have done more, as the judge stated at [25]. However, we do not read that paragraph as meaning he was dissatisfied by the evidence provided by the appellant in the first stage analysis.

33. We have to say at this point that a finding that there was significant doubt about the availability of treatment for a serious and unusual lung condition in Iraq, a country rebuilding after years of conflict, is not one which surprises us.

34. Mr Terrell drew our attention to the negative phrasing in the second sentence of [27] of the decision: "I am not satisfied that adequate treatment would be available", suggesting that by stating that a positive state of affairs had not been established by evidence, he must have asked himself the wrong question. The correct question was whether the appellant had established there was doubt about the availability of treatment. We considered that Mr Terrell's position constituted an overly sophisticated reading of the decision and we find the judge was simply expressing his finding on the stage 1 test. This is quite clearly shown by the fact he continued in [27] to note that it was for the respondent to dispel the serious doubts about it.

35. Mr Terrell may also have overstated the test by referring to "strong evidence" given the Court of Appeal limited its use of this test to the evidence which it could reasonably be expected would fall within the appellant's knowledge: serious illness, treatment, consequences of loss of treatment (see [48] of the judgment). All the Court said the appellant had to do was to provide sufficient evidence to cast doubt on the availability of treatment.

36. Drawing on his findings about the absence of any evidence on this issue from the respondent, the judge concluded the respondent had "singularly failed to do this". That is stage 2. He noted the lack of challenge to the appellant's assertions that his father, who had previously paid for his treatment, had passed away. He also accepted the appellant's condition had deteriorated (see [26] of the decision).

37. We are satisfied the judge correctly applied the law and was entitled to find there had been a burden on the respondent which had not been discharged. The first ground fails.

38. Moving on to the second ground, the judge considered whether the consequence of the removal of adequate treatment would meet the high threshold of intense suffering or a significant reduction in life expectancy. He noted at [27] that the appellant was likely to require a lung transplant and that the consequence of inadequate treatment would be survival for "less than" five years. At [28] the judge concluded that for a 40-year old man, survival for "less than" five years would amount to a substantial reduction in life expectancy. He received no submissions to the contrary from Ms Foster. As said, Mr Terrell did not labour this point and it seems to us that the judge was entitled to conclude as he did.

39. We have reminded ourselves of the discussion of this point in AM (Zimbabwe) as follows:

> "31. It remains, however, to consider what the Grand Chamber *did* mean by its reference to a "significant" reduction in life expectancy in para 183 of its judgment in the *Paposhvili* case. Like the skin of a chameleon, the adjective takes a different colour so as to suit a different context. Here the general context is inhuman treatment; and the particular context is that the alternative to "a significant reduction in life expectancy" is "a serious, rapid and irreversible decline in … health resulting in intense suffering". From these contexts the adjective takes its colour. The word "significant" often means something less than the word "substantial". In context, however, it must in my view mean substantial. Indeed, were a reduction in life expectancy to be less than substantial, it would not attain the minimum level of severity which article 3 requires. Surely the Court of Appeal was correct to suggest, albeit in words too extreme, that a reduction in life expectancy to death in the near future is more likely to be significant than any other reduction. But even a reduction to death in the near future might be significant for one person but not for another. Take a person aged 74, with an expectancy of life normal for that age. Were that person's expectancy be reduced to, say, two years, the reduction might well - in this context - not be significant. But compare that person with one aged 24 with an expectancy of life normal for that age. Were his or her expectancy to be reduced to two years, the reduction might well be significant."

40. We take from this that the test is to be placed in the context of the facts. The reduction in life expectancy must be substantial. The Court gives an illustration of a reduction of two years for a person aged 24 but plainly without intending to lay down any sort of arithmetical test.

41. The judge's decision in this case was perhaps generous, but not a conclusion he was not permitted to reach. The second ground fails as well.

NOTICE OF DECISION

The decision of the First-tier Tribunal did not involve the making of an error of law and shall stand.

Signed: N Froom

Deputy Upper Tribunal Judge Froom Dated: 3 January 2024