Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Numbers: PA/12271/2019**
PA/00746/2020
PA/00747/2020
PA/00748/2020

THE IMMIGRATION ACTS

Heard at Field House **Decision & Reasons Promulgated**
On 18th October 2021 **On 11th November 2021**

Before

UPPER TRIBUNAL JUDGE FRANCES

Between

S A C
MD R A
A A
Al A
(ANONYMITY DIRECTION MADE)

Appellants

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellants: Mr D Balroop, instructed by The Sethi Partnership Solicitors
For the Respondent: Mr T Melvin, Home Office Presenting Officer

DECISION

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1. The Appellants are citizens of Bangladesh. They are a mother, father and two children aged 5 and 3 years old. I shall refer to the first Appellant as the Appellant and the remaining Appellants, her dependants, as RA, AA and AlA. RA arrived in the UK on 25 December 2006.

2. The Appellant came to the UK on 13 March 2013 as a student. Her leave was curtailed in 2014 and her subsequent application was refused. She married RA on 10 August 2015 and their daughters were born in April 2016 (AA) and June 2018 (AlA). The Appellant claimed asylum on 24 August 2016. Her application was refused on 10 September 2017 and her appeal dismissed by First-tier Tribunal Judge Hamilton on 16 February 2018. Her further submissions of 28 August 2019 were refused on 29 November 2019. The Appellant appealed on the grounds that removal would breach Article 8 and Article 3 (in respect of AA's medical condition).

3. The Appellant's appeal was dismissed by First-tier Tribunal Steer on 3 March 2020. This decision was set aside for the reasons given in my decision promulgated on 30 November 2020. None of the judge's findings on Article 3 and Article 8 at [34] to [64] were preserved. The issues were limited to a claim under Article 3 in respect of AA's medical condition and Article 8, outside the immigration rules, in respect of all four Appellants.

4. The following matters are not in dispute. AA is a 5 years and six months old girl with complex and multiple medical needs. She suffers from perinatal hypoxic ischemic encephalopathy, spastic-dystonic quadriplegic cerebral palsy, focal epilepsy, severe generalised body dystonia with repeated episodes of status dystonicus, microcephaly, sleep problems and gastro-oesophageal reflux. She is fed through a PEG, which is a tube through which feeds are passed directly into the stomach and intestines, because her swallowing is unsafe. AA is unable to walk or sit up and has a special chair for ordinary sitting at home and a special transport and bath chair. She is not able to talk and is fully dependent on her carers for all her personal needs. This is likely to be the case for her entire life and is not expected to improve. AA is under the care of the Royal London Hospital and community teams comprising community paediatrician, dietician, speech and language therapist, physiotherapist, occupational therapist and the orthotics department.

5. AA is currently receiving the following medications:

    (i) Omeprazole 20mg (once daily)

    (ii) Movicol Paediatric Sachet (one daily)

    (iii) Orabase (applied around the PEG site as required)

    (iv) Trihexyphenidyl 14mg (twice daily)

    (v) Gabapentin 325mg (thrice daily)

(vi) Clonidine 200mcg (25mcg morning and lunchtime and 150mcg at night)

(vii) Clobazam 5mg (twice daily)

(viii) Sodium Valproate 10ml (twice daily)

(iv) Levetiracetam 550mcg (twice daily)

(v) Chloral Hydrate 1000mcg (once at night)

(vi) Ranitidine 3ml (twice daily)

6. The documentary evidence relied on is in the agreed bundle of 215 pages [A1]. The Appellant also relied on the bundle of 243 pages [A2] which was before the First-tier Tribunal.

Oral evidence

7. The Appellant gave evidence relying on her various witness statements as evidence in chief. In response to supplementary questions from Mr Balroop, she stated she had two sisters (one in the UK and one in the USA) and one brother (in the UK). None of her siblings lived in Bangladesh. They were all married and had children of their own. Her father had passed away and her mother lived with her uncle and his family in Bangladesh. Her uncle has got a small grocery shop. Her husband’s parents had passed away. He had two sisters (one in the UK and one in Bangladesh). The Appellant received no financial support from family members. AA had recently been in hospital with a chest infection. They previously lived in one room in a six bedroomed shared house. This was not suitable for AA and they had been moved to another house so that AA now had her own room on the ground floor.

8. In cross-examination, the Appellant stated she had an interpreter at the previous hearing to help her explain better. There were no witness statements from her siblings or her husband’s siblings. Her relationship with her extended family was not good because they were not happy with her relationship with her husband. Her brother, who lives in the UK, paid her fees when she was a student. He would not offer help or support because he did not accept her relationship with her husband. Her family in Bangladesh lived in Sylhet. Her husband was could not work because they were both needed to look after AA. She could not employ a carer and could not care for AA by herself.

9. In response to questions from me, the Appellant stated a community nurse came every two weeks to check the PEG and oxygen. AA was initially at school for three days a week and was now going full time. She had been transferred to a new school near their new home. She

had a five minute journey to school instead of 40 minutes. AA had a specially designed wheelchair and needed special transport.

10. In response to further questions from Mr Melvin, the Appellant stated her husband could not work while AA was at school because he was not allowed to. He would work if he could. After school the Appellant and AA needed help. She did no know if schools were available for AA in Bangladesh. She did not think there was similar provision as in the UK. There was no re-examination.

Submissions

11. Mr Melvin relied on his skeleton argument, the refusal letter and the response to the request for information [RIR] dated 25 March 2021. Her submitted the Appellant’s asylum appeal had been dismissed and her claim to have received threats from her family was found not credible. Mr Melvin submitted there were no statements from extended family members and I should treat her evidence about the lack of family support with caution.

12. Mr Melvin submitted the situation described by the Appellant did not reach the high threshold of Article 3. Treatment was available for AA, but not of the same standard as in the UK. There was no medical evidence of AA’s life expectancy and no reduction had been shown. The doctor’s opinion on quality of life should attract little weight as he was not an expert on Bangladesh. Mr Melvin submitted I should attach little weight to the letters from pharmacies in Bangladesh because there was no evidence of what questions were asked. There was no reason why AA could not go to school in Bangladesh and RA could go to work. The Appellant made no enquiries about education and care in Bangladesh.

13. Mr Balroop relied on his skeleton argument and submitted this was an extremely difficult case. There was sufficient evidence, given the amount of medication required, to demonstrate a prima facie case. There was no substitute for choral hydrate and treatment was not available for AA. This was not a case where different medications could be easily substituted or tried out. He submitted I should err on the side of caution and give AA the benefit of the doubt.

14. Mr Balroop referred to the disclaimer in the RIR and submitted the response was based on publicly available information in December 2020. There was evidence from the hospital in Sylhet and two pharmacies to show that some of the medications, which the Respondent claimed were available, were not available. The Appellant’s evidence was preferable because it post-dated the RIR. There was no evidence from the Respondent to contradict this evidence.

15. Mr Balroop submitted the Respondent accepted AA required medication on a daily basis. Even if that medication was available, AA could not access it because of the cost, lack of a support network and geographical location. The Appellants had to have suitable accommodation available to them on arrival in Bangladesh. On the evidence, this was not possible because no one in Bangladesh could provide the support AA required. Notwithstanding extended family members in the UK, the Appellants lived in one room in a shared house not with other family members. There was credible evidence that the Appellants did not have support in the UK. The family members in Sylhet, where there was only one hospital, were unable to provide a support network to enable AA to access appropriate treatment.

16. Mr Balroop submitted any change in AA's medication had to be carefully monitored and managed. There was no treatment for cerebral palsy in Sylhet. There was no special wheelchair or bath seat available in Bangladesh. There was also evidence that AA could not fly to Bangladesh. The Respondent had failed to dispel any serious doubts that medication is available and accessible in Bangladesh.

Summary of medical evidence

17. The Appellant relies on letters, dated June 2021, from AA's consultant community paediatrician, consultant in paediatric neurology, community nursing team and department of paediatric medicine in addition to the medical reports in bundle A2.

18. AA's consultant community paediatrician, Dr Sodeinde, after summarising AA's condition and current medication (set out at [4] and [5] above), is of the opinion that "difficulty in accessing the various treatments specified above would have very grave implication indeed for the health, prognosis and eventual outcomes for this child. Survival is likely to be severely compromised."

19. AA's consultant in paediatric neurology, Dr Yoong, describes the medical problems from which AA suffers as a result of the severe brain injury from lack of oxygen during a difficult birth. AA has multiple seizures every day despite treatment with three different anti-epileptic medications (levetiracetam, sodium valproate and clobazam). Her seizures are brief and sufficiently controlled by this medication. She would be at risk of her epilepsy deteriorating if she could not access a regular supply of her medications which would represent "a significant deterioration in her health and potentially present a risk to her life. Any alteration to her antiepileptic medications should only be made with caution and under appropriate medical supervision (ideally an experienced paediatric neurologist)."

20. AA's cerebral palsy "manifests itself as an inability to control her movements and a tendency for her muscles to be stiff (spasticity) and become stuck in painful and awkward positions (dystonia)." She is currently receiving the following medication: clonidine, trihexyphenidyl and gabapentin. Dr Yoong states:

> "It has proved difficult over the years to find the right balance of medications for her to prevent significant dystonic episodes but not make her too sleepy. When she was younger her dystonia was much more of a problem and she had a number of admissions to hospital with status dystonicus, a life threatening complication where a child has uncontrollable dystonia for hours-days. If any of these medications were suddenly withdrawn then she would be at risk of going into status dystonicus again. Again, any alteration to her dystonia medications should only be made with caution and under appropriate supervision."

21. AA suffers from gastro-oesophageal reflux, a common complication of cerebral palsy, where there is a tendency for her stomach contents to travel the wrong way up her gullet. This is often painful and there is a risk they may enter her lungs and cause a chest infection. She is treated with omeprazole and fed through a feeding tube with a specialist feed that is managed by her dietician. AA is also often sleepy in the day and awake at night. She is treated with chloral hydrate which is an important medication for her quality of life.

22. In summary, Dr Yoong expresses the following opinion:

> "While I am unable to comment on the quality of the care that would be available to her in Bangladesh, in my experience of children who have arrived in the UK from Bangladesh, it is unlikely to be of the same standard and wholistic (sic) nature as the care that she is currently receiving and will result in both a reduction in her quality of life and her life expectancy."

23. In relation to alternative medication, Dr Yoong could not comment on the suitability of cimetidine as a replacement for ranitidine. He is of the opinion that nitrazepam is not a useful agent for treating sleeping disorders because a dose sufficient to sedate AA would run the risk of affecting her airway and her ability to breathe. It was also of the same family as clobazam which AA is currently taking and any side effects would be compounded. He was not aware of any medical reason why AA could not board an aircraft and travel. Dr Yoong stated AA no longer required midazolam (nasal spray).

24. In conclusion, Dr Yoong stated he would not recommend that any of her neurological medications be withdrawn as they were all important in maintaining AA's health. He stated: "In particular, the sudden cessation of any of her neurological medications risk precipitating a life-threatening emergency."

25. The Appellant submitted a printout from the National Institute for Health and Care Excellence [NICE] which showed that cimetidine and nitrazepam are only licensed for use in adults in the UK. The Appellant stated AA is currently taking melatonin and her dose could not be increased.

26. The Appellant relied on a letter from MAG hospital in Sylhet dated March 2021 which stated treatment for AA's complex medical condition was not available and an electric wheelchair, special needs bed and bathroom could not be provided. Letters from two pharmacies in Sylhet dated March 2021 stated that trihexyphenidyl, gabapentin, clonidine, clobazam, buccolam and chloral hydrate were not available.

27. The Country Policy and Information Note Bangladesh: Medical and Healthcare Issues [CPIN] May 2019 states there is a paediatric neurology department in the 350 bed hospital in Dhaka and an intensive care unit the public children's hospital. The list of medication available from April 2017 to March 2019 listed clonidine and omeprazole.

28. The RIR dated 25 March 2021 stated inpatient and outpatient treatment by a paediatrician, paediatric neurologist and ENT specialist was available at the MAG hospital in Sylhet. Outpatient treatment by a gastroenterologist (feeding tube treatment), paediatric physiotherapy and occupational therapy was also available. Oxygen could be supplied in a home situation. An electric wheelchair was only available in Dhaka. A bath seat for a child was not available.

29. The list of medications available as of 22 December 2020 included: gabapentin, levetiracetam, valproic acid/valproate/Depakine, clonazepam (buccal form), midazolam (oromucosal solution) and trihexyphenidyl. Possible alternatives to these medicines were: diazepam (suppository), carbamazepine, lamotrigine, topiramate, baclofen and nitrazepam.

30. Ranitidine was not available in Sylhet. Cimetidine was available as an alternative. Choral hydrate was not available. Nitrazepam and melatonin were available alternatives. Medication was normally provided free of charge in public hospitals and all pharmacies must adhere to a maximum retail price.

Factual findings

31. I find the Appellant gave credible evidence in relation to AA's medical condition and the lack of support from extended family members. I am not persuaded by Mr Melvin's submission that her evidence should be treated with caution because her asylum claim was

rejected. The Appellant gave clear and cogent evidence of her extended family members in the UK and in Bangladesh.

32. The Appellants have not lived with family members in the UK. They have been living in one room in a shared house for several years provided to them as asylum seekers. The room contained three beds and AA had to be carried up and downstairs to the bathroom. They have recently moved to a more suitable property. The medical reports and documentary evidence in the Appellant's bundle demonstrate that the Appellant and her husband, RA, provide 24 hour care for AA. There is no suggestion that other family members are involved in any way. I accept the Appellant's evidence that she receives no support from her family in the UK.

33. I also accept her evidence that her elderly mother lives with her uncle and his family in Sylhet and they would not be able to assist with providing accommodation or support for AA's complex needs. The report from the London Borough of Havering occupational therapy team demonstrates AA requires specific accommodation with wheelchair access and her own bedroom to meet her needs.

34. I find AA is cared for by both her parents with the assistance of a community nurse. The Respondent accepts it would be in the best interests of AA to remain in the UK given the significant disruption she would face in the medical and social care she receives in the UK.

35. There is no dispute that AA suffers from severe and complex medical conditions which are managed by specific medications. It is apparent from the evidence above that the following medications are not available in Bangladesh: clonidine, clobazam, chloral hydrate and ranitidine.

36. Dr Yoong could not comment on the use of cimetidine as an alternative to ranitidine. However, there was evidence before me to show that it was not licenced for use in children in the UK. I find that there are no suitable alternative medications for ranitidine.

37. Dr Yoong would not recommend the use of nitrazepam as an alternative to choral hydrate. Melatonin may be a suitable alternative to chloral hydrate. It is unfortunate there was no medical evidence to support the Appellant's evidence that AA was currently taking melatonin and her dose could not be increased. The earlier medical reports show that AA was prescribed melatonin in addition to chloral hydrate to help her sleep. This evidence suggests that melatonin in itself was insufficient to address AA's sleeping difficulties. I find there are no suitable alternative medications for chloral hydrate.

38. AA requires clobazam to manage her epilepsy and clonidine to manage her dystonia. Neither are available in Bangladesh and the

Respondent has failed to show there are suitable alternatives available.

39. I find on the totality of the evidence that four of AA's eleven medications are not available in Bangladesh and there are no suitable alternative medications available for AA. I am satisfied the medical evidence demonstrates that AA requires all of the medications listed above on a daily basis and withdrawal of any of her medications would have very serious consequences to her health which could be life threatening.

Conclusions and reasons

40. There is no dispute the Article 3 threshold is a high one and the Appellant has to adduce evidence capable of demonstrating substantial grounds for believing that Article 3 would be violated: AM (Zimbabwe) v SSHD [2020] UKSC 17. The Appellant has to show that AA, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in Bangladesh or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in AA's state of health resulting in intense suffering or a significant reduction in life expectancy.

41. On the totality of the evidence, I am satisfied that removing AA to Bangladesh would breach Article 3 for the following reasons. AA's epilepsy is treated with clobazam which is not available in Bangladesh. The medical evidence demonstrates that if AA does not receive any one of her three medications to treat epilepsy she is at risk of a significant deterioration in her health and there is a potential risk to her life. AA's dystonia is treated with clonidine which is not available in Bangladesh. AA would be at risk of status dystonicus, which is a life threatening condition, if she cannot access any one of her medications for dystonia. I am satisfied that the absence of this treatment would result in intense suffering for AA and potentially a risk to her life.

42. It is accepted the Appellant cannot satisfy the immigration rules. The Appellant has remained in the UK illegally since 2014 and has formed her family and private life whilst she had no right to remain in the UK. Applying section 117B of the 2002 Act, I attach significant weight to the public interest and little weight to the Appellant's private life.

43. AA and AlA are both very young and it is in their best interests to remain with the Appellant and RA, their parents. It is accepted it is in AA's best interests to remain in the UK. Given my findings above, AA's medical condition gives rise to exceptional circumstances such that the refusal of leave to remain will result in unjustifiably harsh consequences for AA. On the particular facts of this case, I find the

best interests of AA outweigh the public interest. The refusal of leave to remain is disproportionate.

44. In conclusion, I find that AA's removal to Bangladesh would breach Article 3. This factor is determinative of this appeal. The refusal of leave to remain in respect of all four Appellants breaches Article 8.

Notice of decision

The appeals are allowed on human rights grounds.

AA's appeal is allowed under Articles 3 and 8.

The appeals of the Appellant, RA and AlA are allowed on Article 8 grounds.

Direction Regarding Anonymity – Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008

Unless and until a Tribunal or court directs otherwise, the Appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify him or any member of his family. This direction applies both to the Appellant and to the Respondent. Failure to comply with this direction could lead to contempt of court proceedings.

J Frances

Signed Date: 1 November 2021
Upper Tribunal Judge Frances

TO THE RESPONDENT
FEE AWARD

I make no fee award. The Appellant's asylum claim was dismissed.

J Frances

Signed Date: 1 November 2021
Upper Tribunal Judge Frances

NOTIFICATION OF APPEAL RIGHTS

1. A person seeking permission to appeal against this decision must make a written application to the Upper Tribunal. Any such application must be **received** by the Upper Tribunal within the **appropriate period** after this decision was **sent** to the person making the application. The appropriate period varies, as follows, according to the location of the individual and the way in which the Upper Tribunal's decision was sent:

2. Where the person who appealed to the First-tier Tribunal is **in the United Kingdom** at the time that the application for permission to appeal is made, and is not in detention under the Immigration Acts, the appropriate period is **12 working days (10 working days, if the notice of decision is sent electronically).**

3. Where the person making the application is in detention under the Immigration Acts**, the appropriate period is 7 working days (5 working days, if the notice of decision is sent electronically)**.

4. Where the person who appealed to the First-tier Tribunal is **outside the United Kingdom** at the time that the application for permission to appeal is made, the appropriate period is **38 days (10 working days, if the notice of decision is sent electronically).**

5. A "working day" means any day except a Saturday or a Sunday, Christmas Day, Good Friday or a bank holiday.

6. The date when the decision is "sent' is that appearing on the covering letter or covering email