



Home Office

Medical claims under Articles 3 and 8 of the European Convention on Human Rights (ECHR)

Version 8.0

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About this guidance

This guidance tells you how to consider applications for leave to remain on medical grounds where a claimant claims that removing them from the UK would breach their human rights. A Human Rights claim on medical grounds relies on the following articles of the European Convention on Human Rights (ECHR):

- Article 3 – inhuman or degrading treatment
- Article 8 – respect for private life, including moral and physical integrity

This guidance does not cover Article 8 ECHR claims on private life grounds other than those based on medical grounds. For guidance on Article 8 private life claims, see separate guidance on long residence and appendix FM and 276ADE (family members and private life); this guidance does not cover applications for leave to enter based on seeking medical treatment.

For criminality cases, this medical claims guidance must be read in conjunction with the Criminality guidance for Article 8 ECHR cases.

Contacts

If you have any questions about the guidance and your line manager or senior caseworker cannot help you or you think that the guidance has factual errors then email Asylum Policy.

If you notice any formatting errors in this guidance (broken links, spelling mistakes and so on) or have any comments about the layout or navigability of the guidance then you can email the Guidance Rules and Forms team.

Clearance

Below is information on when this version of the guidance was cleared:

- version **8.0**
- published for Home Office staff on **19 October 2020**

Changes from last version of this guidance

Changes in this version include:

- amendments for clarification of caselaw in relation to mental health
- amendments for clarification to considering medical evidence section

Previous changes to this guidance include:

- updated and re-branded

- additional guidance on transplant cases
- updated to reflect recent case law on medical issues and the Article 3 test

Related content

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Purpose of instruction

This guidance covers applications for leave to remain on medical grounds under Articles 3 and 8 of the European Convention on Human Rights (ECHR). It reflects the latest case law that must be considered and sets out the high threshold to be applied in medical and mental health cases, so that leave is only granted on medical grounds in exceptional circumstances.

Background

A claimant may claim that requiring them to leave the UK would breach their human rights due to a serious medical condition, which could be a physical illness or mental health issue. Such cases must be considered in accordance with our obligations under Articles 3 and 8 of the ECHR.

The threshold in Article 3 medical cases is very high, as set out in the UK Supreme Court case of [AM \(Zimbabwe\) \[2020\] UKSC 17](#), which affirmed the Article 3 medical threshold as set out in the European Court of Human Rights case of [Paposhvili v Belgium \[2017\] Imm AR 867](#).

Following AM (Zimbabwe) it is Home Office policy to accept that a claimant's Article 3 (medical) rights would be breached where there are substantial grounds for believing that they would face a real risk of being exposed to a serious, rapid and irreversible decline in their state of health resulting in intense suffering or a significant (substantial) reduction in life expectancy as a result of the absence of appropriate medical treatment or lack of access to such treatment in the country of return. The claimant must provide evidence capable of demonstrating that there are "substantial" grounds for believing that they would be exposed to a real risk of being subject to "inhuman" treatment contrary to Article 3. In countering such evidence, the returning state must dispel any serious doubts raised by the evidence provided.

Only in very exceptional cases, where the humanitarian grounds against removal are particularly compelling, will an Article 3 medical claim succeed. The test to be applied requires consideration of a range of factors based on the individual facts of each case, of which availability and accessibility of treatment is a key factor, and only where the high threshold has been met will a grant of leave on medical grounds be appropriate.

The focus of Article 8 medical claims is on the quality of an individual's life, as set out in the Court of Appeal case of [GS \(India\) & Ors v the SSHD \[2015\] EWCA Civ 40](#). Article 8 medical claims therefore form part of the balancing exercise which takes place when considering Article 8 claims although it should be noted that there must be a strong healthcare case before Article 8 is even engaged [R \(Razgar\) v Secretary of State for the Home Department \[2004\] UKHL 27](#).

This policy is designed to protect the National Health Service (NHS) and deter people from coming to the UK to seek free health care, so-called 'health tourism'.

Disparities exist between healthcare systems around the world and it would place an intolerable and unrealistic burden on the finite resources available in the NHS if the UK were expected to provide free and unlimited healthcare to all those without a legal right to stay. That is why those who do not qualify to remain under any other provisions of the Immigration Rules are normally expected to leave the UK even where this would be difficult due to a serious physical or mental illness.

Policy intention: medical claims

The policy intention in considering applications for leave to remain on medical grounds is to balance the needs of claimants who have serious medical conditions with the wider public interest by:

- properly considering medical claims with sensitivity and granting leave outside the Immigration Rules in very exceptional cases, where there is strong medical evidence that removal would breach Article 3 or 8 of the ECHR
- protecting finite NHS resources by removing those who have no right to remain here even where they have a medical condition, if that does not meet the very high threshold that applies in such cases
- ensuring that access to health services does not act as an incentive for migrants to come to the UK illegally for medical treatment (health tourism)

Application in respect of children: medical claims

When applying this guidance, you must take into account the circumstances of each case and, in particular, the impact of your decision on any child in the UK who is or may be affected by it. For example, a child may be affected by your decision if they are the claimant suffering from the illness, or they are the family member of such a claimant. [Section 55 of the Borders, Citizenship and Immigration Act 2009](#) obliges the Secretary of State to take account of the need to safeguard and promote the welfare of children in the UK when carrying out immigration, asylum and nationality functions. All decisions must demonstrate that the child's best interests have been considered as a primary (albeit not necessarily the only) consideration.

The section 55 duty applies whether the child applies in their own right or as the dependant of a parent or guardian. Home Office guidance [Every Child Matters – Change for Children](#) sets out the key principles to take into account in all cases involving a child in the UK.

You must also be vigilant that a child may be at risk of harm and be prepared to refer cases immediately to the safeguarding hub for referral to a relevant safeguarding agency where child protection issues arise.

Where you consider it is appropriate to grant leave to a child based on a medical condition, you must also consider the length of leave to be granted. A decision about the duration of leave granted outside the rules is an immigration function to which [section 55](#) applies. The length of leave must be decided on the individual facts of the case. While a grant of 30 months leave will normally be appropriate, leave may be

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granted for shorter or longer periods, including, in particularly compelling circumstances, indefinite leave to remain. You must demonstrate in the decision letter that you have thought about the child's best interests when considering the type and length of leave following a decision to grant leave under this policy. See discretionary leave guidance for details on the duration of leave.

The threshold for a breach of Article 3 in cases involving children is the same high threshold that applies in cases involving adults. However, in [R \(SQ \(Pakistan\)\) v Upper Tribunal \(Immigration and Asylum Chamber\) \[2013\] EWCA Civ 1251](#), the Court of Appeal noted that the question of whether or not the level of severity is reached to establish an Article 3 claim will depend on the circumstances of the case. Accordingly, the Court of Appeal recognised that there would be circumstances in which the threshold would be reached in relation to a child where it would not be reached in the case of an adult.

In the context of an Article 8 medical claim, Maurice Kay LJ went on to observe in [SQ \(Pakistan\)](#) that the decision in [ZH \(Tanzania\) v SSHD \[2011\] UKSC 4](#):

“...demonstrates the central role of the best interests of a child in an Article 8 case”, adding (at paragraph 26), “what this case demonstrates is that in some cases, particularly but not only in relation to children, Article 8 may raise issues separate from Article 3”.

The claim was remitted to the Tribunal for further consideration of the child's position.

However, [SQ \(Pakistan\)](#) also makes plain that even in Article 8 cases involving children, the fact that the child is a health tourist, if that is the case, and indeed the cost of the child's ongoing care to the state, will remain relevant to the proportionality analysis. See paragraph 27, which states:

“On the one hand, MQ can pray in aid his lawful entry and his status as a child with the protection of the ZH approach. On the other hand, he arrived with his serious medical conditions at an advanced stage and although not an unlawful entrant, it will be relevant to consider whether his arrival here was a manifestation of health tourism. If it was, that would fall to be weighed in the balance. After all, this country is under no international obligation always to act as the hospital of the world...”

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Relevant legislation and case law

This section sets out the legal framework that applies to the consideration of Article 3 and Article 8 medical and mental health cases.

International law

The Convention for the Protection of Human Rights and Fundamental Freedoms (commonly referred to as the European Convention on Human Rights (ECHR)) seeks to secure a fair balance between the general interests of society and protection of the claimant's fundamental rights. The articles of particular relevance in medical claims are:

- **Article 3:** provides protection against torture or inhuman or degrading treatment or punishment – in medical claims a claimant may claim that their return would amount to inhuman or degrading treatment, in light of the disparity between medical treatment being received in the UK and that available in the country of proposed return (Article 3 is an absolute, unqualified right)
- **Article 8:** provides that everyone has the right to respect for their private and family life - a claimant's medical condition is relevant to their moral and physical integrity, which is a component of private life (unlike Article 3, Article 8 is a qualified right)

Domestic legislation

Section 3(1) of the [Immigration Act 1971](#) provides the power to grant leave to enter or remain in the UK and **Section 3(1)(c)** provides powers to impose conditions on that leave.

The [Human Rights Act 1998](#) incorporated into UK domestic legislation our obligations under the ECHR. It allows cases concerning ECHR rights to be brought in the UK courts.

Important case law

The following cases are important case law concerning the consideration of medical claims:

[AM \(Zimbabwe\) \[2020\] UKSC 17](#), affirmed the Article 3 medical threshold as that held in [Paposhvili v Belgium \[2017\] Imm AR 867](#) and provided the Supreme Court's interpretative steer which is now the test to follow when considering Medical Claims (Article 3). AM (Zimbabwe) sets out the test and approach for determining whether removal of a claimant from the UK would breach Article 3 of the ECHR as a result of the claimant's medical condition. The Supreme Court's decision is now the leading

authority on the issue of Article 3 medical claims and replaces the previous House of Lords decision of [N \[2005\] UKHL 31](#). There are two elements to determining an Article 3 medical claim: a) the substantive test and b) the procedural obligations. These 2 elements are interlinked and must both be addressed by the Home Office when making a decision in order to prevent a breach of Article 3 on medical grounds.

In [Paposhvili v Belgium \[2017\] Imm AR 867](#) the European Court of Human Rights (ECtHR) clarified its previous approach in [N v UK \(2008\) 47 EHRR 39](#). The ECtHR shifted the boundary of Article 3 protection from those who were about to die in the removing state to those who would face a serious, rapid and irreversible decline in their health leading to intense suffering and/or a significant reduction in their life expectancy either because of the absence of treatment or inaccessibility of treatment in the country of return. The Supreme Court in AM (Zimbabwe) has now endorsed the approach in Paposhvili and so that approach is now binding on UK domestic courts.

[GS \(India\) & Ors v the SSHD \[2015\] EWCA Civ 40](#)) had reaffirmed the high threshold set in N in Article 3 cases but this has now been replaced and AM (Zimbabwe) is the lead authority on the Article 3 test to be followed. GS also affirmed MM (Zimbabwe) in stating that Article 8 was potentially relevant in a medical case but would only affect the analysis if it could be shown that another element of the claimant's Article 8 rights (family life or an aspect of private life other than health) were also engaged by removal.

[MM \(Zimbabwe\) v SSHD \[2012\] EWCA Civ 279](#) considered the relevance of medical matters to the Article 8 analysis, concluding that such matters would be unlikely to affect the outcome of a case absent of other Article 8 factors in the claimant's favour.

[JA \(Ivory Coast\) and ES \(Tanzania\) v SSHD \[2009\] EWCA Civ 1353](#) (paragraph 16) referred, in the context of an Article 8 medical claim, to the fact that the UK cannot afford to be the world's healthcare system of choice, stating that in relation to purposes which could interfere with a person's private life:

“Here the prescribed purposes are, or include, the economic wellbeing of the country, which cannot afford to be the world's hospital, and the prior right of a settled population to the benefit of its inevitably finite health resources.”

[Bensaid v UK – 44599/98 \[2001\] ECHR 82 \(6 February 2001\)](#) recognised that mental health claims could fall within the scope of Articles 3 and 8 of the ECHR.

In [RA \(Sri Lanka\) v SSHD \[2008\] EWCA Civ 1210](#) (paragraph 49), the Court of Appeal held that in Article 3 cases, the same principles apply to mental illness and suicide cases as they do to physical illness cases. Neither the ECtHR in Paposhvili, nor the Supreme Court in AM (Zimbabwe) considered Article 3 mental health medical claims and so did not comment on whether RA (Sri Lanka) was still correct. The principles in AM (Zimbabwe) therefore apply to cases of mental illness and/or suicide risk. It is necessary to consider whether appropriate treatment to reduce the risk of suicide is available and accessible in the receiving country. Treatment may not be accessible if the person is too traumatised by previous hostile actions of the

receiving state to be able to access it and has no family support to help them to do so (see [Y and Z v Secretary of State for the Home Department \[2009\] EWCA Civ 362](#)).

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Medical claims as protection cases case law

Findings from the Court of Justice of the European Union (CJEU) and the UK Supreme Court's view in the following cases are of particular relevance in relation to claims that medical cases can amount to protection claims:

[MP \(Sri Lanka\) \[2018\] EUECJ C-353/16](#) considered a claimant who has in the past been tortured in his country of origin but no longer faces a real risk of torture on return is eligible for 'subsidiary protection' if he faces a real risk of being intentionally deprived, in that country, of appropriate physical and psychological health care. The court confirmed that this was a matter to be determined by national courts.

In [MP\(Sri Lanka\) v Secretary of State for the Home Department; & Anor case \[2016\] UKSC 32](#), the Supreme Court referred to the CJEU the question of whether Article 2(e), read with Article 15(b) of the Qualification Directive, covers a real risk of serious harm to the physical or psychological health of the claimant if returned to the country of origin, resulting from previous torture or inhuman or degrading treatment for which the country of origin was responsible.

In [Abdida \(CJEU - Case C-562/13 Centre public d'action sociale d'Ottignies-Louvain-La-Neuve v Moussa Abdida, 18 December 2014\)](#) the CJEU held that leave on medical grounds does not come within the scope of the Qualification Directive ([2004/83/EC](#)).

In [M'Bodj \(Mohamed M'Bodj v État belge, C-542/13, European Union: Court of Justice of the European Union, 18 December 2014\)](#) the CJEU held that medical cases fall outside the scope of the Qualification Directive ([2004/83/EC](#)).

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Applications on medical grounds

This section tells you how claimants must apply for permission to stay in the UK based on human rights grounds for medical reasons outside the Immigration Rules.

Article 3 medical issues raised by a claimant with an outstanding asylum claim, will be considered with that claim and there is no need to make a separate application.

Claimants who make a human rights medical claim in response to enforcement action, for example a deportation notice, do not need to submit an application form.

Application forms

Claimants can apply for leave to remain on Article 3 or 8 medical grounds by submitting one of the following application forms:

- [FLR\(HRO\)](#) – for medical grounds or ill health
- [SET\(O\)](#) – to apply for indefinite leave to remain (ILR) outside the Immigration Rules on the basis of having completed:
 - six years Discretionary Leave (DL) (if they were granted DL on or before 8 July 2012)
 - 10 years DL (if they were granted DL on or after 9 July 2012) or
 - 10 years leave outside the Immigration Rules

Article 3 medical applications cannot be made on the [FLR\(DL\)](#) form.

Applications by letter

In most cases, you should normally reject applications made by letter as invalid and send the claimant the [appropriate application form](#) to complete. Whilst an application can be accepted as invalid a human rights claims could still need to be decided prior to any removal action.

In exceptional circumstances you can accept an application as valid if the letter is submitted with acceptable medical evidence demonstrating the urgency of the application. Evidence is only acceptable if all the following apply:

- it is provided by an appropriate NHS clinician or consultant currently involved in the claimant's care
- it confirms the claimant is gravely ill and
- it confirms the claimant has only weeks to live despite ongoing treatment in the UK

Charging: Article 3 only

Human rights claims based on Article 3 medical grounds, which are considered under the terms of this policy, are fee exempt.

Charging: Articles 3 and 8 mixed applications

Where a claimant makes an application to remain in the UK on medical grounds in which Article 3 of the ECHR is cited alongside other articles of the ECHR, the whole application will be uncharged provided the claim in respect of Article 3 constitutes a genuine basis of the application and has a realistic prospect of success, when considered against the very high threshold that applies (as set out in this guidance).

Where medical issues have been cited alongside other Article 8 family issues, for example an established private life, and the medical issues do not reach the medical claims threshold, the application must be rejected if payment of the fee for an Article 8 application is not received (following being given the opportunity to make the payment). See [GOV.UK](https://www.gov.uk) for the correct private and family life application form.

Implied medical claims

There may be cases where a claim on medical grounds is implied rather than explicitly cited by the claimant. This may be referred to in the application or covering letter. To work out whether such a claim has been implied, you must check the application form, covering letter (if any) and supporting documents for the following indicators:

The claimant seeks:

- leave outside the rules (LOTR) or Discretionary Leave (DL) on medical grounds, or to receive medical treatment on the NHS
- the claimant expresses fear of return, is unwilling to return, or wants to remain in the UK because medical facilities in their home country are not:
 - available
 - affordable
 - accessible
 - of the same standard as treatment in the UK
- the claimant refers to death without dignity abroad because medical treatment in their home country is not:
 - available
 - affordable
 - accessible
 - to the same standard as treatment in the UK

- the claimant refers to either:
 - inhuman and degrading treatment (on medical grounds)
 - Article 3 and/or Article 8 (medical) [case law](#)
- the claimant was previously granted LOTR or DL on medical grounds and asks for further leave on the same basis

You must not disregard an application as a human rights medical claim just because the claimant:

- has not used the terms 'Article 3' or 'Article 8' specifically
- has placed a greater emphasis on Article 8 than Article 3 in their application
- is not in the final stages of a terminal illness
- is under 18 years of age

Requesting confirmation

If you think an application is an implied human rights (medical) claim, or it is unclear on what basis the claimant is applying, you may need to ask the claimant or their legal representative to clarify the basis of their claim in writing.

Claims indicating Refugee Convention protection needs

When a claimant states they cannot access medical treatment in their home country for a reason which falls within the Refugee Convention, for example, being a member of a particular social group, because of their religious beliefs or political opinion or the evidence implies a fear of return for reasons other than those relating to their medical condition, you must:

- send an ASL.1036 'refusal to accept a postal [asylum] claim' letter
- inform the claimant they will need to attend a screening interview and a substantive asylum interview, and provide details of the screening appointment that has been arranged for them
- inform the claimant that the protection claim will not be considered unless or until they make a claim in person in line with the process set out in the '[claim asylum in the UK](#)' section on the GOV.UK website and that if they fail to attend the asylum interview, their asylum claim may be treated as withdrawn under paragraph 333C of the Immigration Rules

Where a claimant is critically ill, and there is sufficient medical evidence provided in the application to justify a grant of leave under this policy, you may grant Discretionary Leave (DL). You must still inform the claimant that if they want to pursue an asylum claim they must do so in person, save in exceptional circumstances. Where it would be unreasonable to expect a claimant to travel to the Asylum Intake Unit, they can request screening to be undertaken locally. Such requests should be made directly to the Immigration Compliance and Enforcement

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(ICE) team, or the local asylum team. Each case will be considered on its individual merits.

Further leave applications

A claimant who has previously been granted leave based on Article 3 or Article 8 medical grounds is subject to a full case consideration when they make a further application for DL or indefinite leave to remain (ILR). The purpose of this consideration is to decide whether the claimant continues to qualify for leave on the same basis, this means a claimant who has previously been granted DL or LOTR on human rights medical grounds will not necessarily be granted further leave if their circumstances have changed.

Further submissions following the refusal of asylum

All claimants who have previously been refused asylum must normally make any protection based further submissions in person, in line with the further submissions process. Provision exists under this policy to allow claimants to submit evidence by post, in exceptional circumstances but they must first obtain permission from the Further Submissions Unit (FSU). See [GOV.UK](#) for details on how to contact FSU. See also Further Submissions guidance.

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Considering medical claims

This section tells you how to consider applications for permission to stay in the UK based on medical grounds against the high threshold required in the context of Article 3. Some cases may engage Article 8 as well. See [Article 8: medical cases](#). If the case involves a child – either as a dependant or as the main claimant – you must refer to the section on [application in respect of children: medical cases](#).

In cases involving children who are the dependants of a claimant with a medical condition, you must consider the impact removal would have on the child. Your decision letter must demonstrate that you have considered all the information and evidence provided concerning the best interests of the child in the UK. You must carefully assess the quality of any evidence provided. Original documentary evidence from official or independent sources about the impact on the child will be given more weight in the decision-making process than unsubstantiated assertions that removal is not in a child's best interests.

There is no provision within the Immigration Rules for a claimant to remain in the UK to access, or to continue to access, medical treatment on the NHS. Such claims usually rely on ECHR Article 3 or Article 8. You may see references to Article 2 of the ECHR citing a 'right to life'; however, Article 2 is not relevant in medical cases as this relates to death inflicted deliberately at the hands of the state not the failure of a state to provide adequate healthcare.

Article 3: medical cases

To engage Article 3 of the ECHR, a claimant must provide evidence that there are substantial grounds for believing that they would face a real risk of being exposed to either a serious, rapid and irreversible decline in their state of health resulting in intense suffering or a significant (substantial) reduction in life expectancy as a result of either the absence of treatment or lack of access to such treatment. If the condition does not reach this threshold the Article 3 medical aspect of the claim must be refused. Less serious conditions may form part of the proportionality analysis under Article 8 but are unlikely to succeed without other factors bringing the claimant within the latter, for example, family life. See [Article 8: medical cases](#).

The threshold in Article 3 medical cases is very high, and is based on the test set out in [AM \(Zimbabwe\) \[2020\] UKSC 17](#) which affirmed the Article 3 medical threshold as that held in [Paposhvili](#) and provided the Supreme Court's interpretative steer. The AM (Zimbabwe) judgment departed from the threshold previously established by the House of Lords in [N](#) but clarified that it is still a high threshold to meet. Only in 'very exceptional circumstances' would Article 3 be capable of being engaged in a medical case. The claimant must provide reliable evidence which can demonstrate 'substantial' grounds for believing that their case is a 'very exceptional case' because of a 'real risk' of being subject to "inhuman" treatment contrary to Article 3.

Substantive test

In order for a claimant to establish that there would be a breach of Article 3 on medical grounds if they were removed from or required to leave the UK, the claimant must show that there are substantial grounds (see step 1 below) for believing that:

- 1) They would face a real risk of being exposed to either:
 - a) a serious, rapid and irreversible decline in their state of health resulting in intense suffering, or
 - b) a significant reduction in life expectancy – ('significant' means 'substantial') and whether a reduction in life expectancy is substantial will depend on the facts of the case

For example, in the cases of a 74 year old and a 24 year old who both have a life expectancy normal for their respective ages (in their country of origin) – if their life expectancies were to be reduced to just two years it might be considered as a substantial reduction for the 24 year old but not the 74 year old.

And

- 2) The serious, rapid and irreversible decline in health leading to intense suffering and/or the significant reduction in life expectancy must be as a result of either:
 - the absence of appropriate treatment in the receiving country, or
 - the lack of access to such treatment

Procedural obligations

When establishing whether the substantive test has been met, the following procedural steps must be followed:

Step 1

The claimant must produce evidence to show that on the face of it there is an infringement of their rights which, if it wasn't challenged, would establish a breach of Article 3 on medical grounds using the substantive test.

To do this they should produce evidence of all of the following:

- their medical condition
- their current treatment for their medical condition
- the likely suitability of any alternate treatment for their medical condition
- the effect that an inability to obtain effective treatment would have on their health

The Supreme Court in [AM \(Zimbabwe\)](#) noted that this essentially means that an individual has to establish a prima-facie case of potential infringement i.e. a case which, if not challenged, would establish a breach of Article 3 by reference to the test above. It is for individuals to adduce evidence about their medical condition; current

treatment; the likely suitability of any other treatment; and the effect of their inability to access it.

Step 2

Once the claimant has established their initial case (that on the face of it there is an infringement of their rights which, if it wasn't challenged, would establish a breach of Article 3 on medical grounds using the substantive test), (the Home Office) you must investigate any serious doubts about whether they can be safely removed from the UK without breaching Article 3 on medical grounds.

This must be done on a case by case basis, using evidence about the availability and accessibility of treatment in the receiving state to decide:

- whether the care and treatment which is generally available in the receiving state is in practice sufficient to prevent a breach of Article 3, and
- whether care and treatment is accessible, taking into consideration:
 - cost
 - the existence of a family/support network, and
 - geographical location

The Supreme Court in [AM \(Zimbabwe\)](#) noted that this essentially means collating evidence about the availability and accessibility of suitable treatment in the receiving state.

Step 3

After (the Home Office's) your investigation, if serious doubts persist, the UK needs to obtain individual assurances from the receiving state that appropriate treatment would be available and accessible to the claimant.

Individual assurances need only be sought where serious doubts remain about whether they can be safely removed from the UK without breaching Article 3 on medical grounds. Individual cases must first be raised with your Senior Caseworker and then referred to Asylum Policy.

In [AM \(Zimbabwe\)](#), the Supreme Court held that the test is a demanding one (paragraph 32) and only a very exceptional case is likely to meet this high threshold. Therefore, only those suffering from very serious medical conditions are likely to be able to show a serious, rapid and irreversible decline in their health resulting in either intense suffering or a substantial decline in their life expectancy caused by a lack of treatment on return resulting from the unavailability or inaccessibility of that treatment.

Each of the limbs of the substantive test need to be satisfied. For example, the test is unlikely to be met in cases where the serious, rapid and irreversible decline in the claimant's health resulting in intense suffering or a significant reduction in life expectancy is not caused by the unavailability or inaccessibility of the required treatment on return. Similarly, the test is unlikely to be met in cases where even

though the treatment the claimant needs is either unavailable or inaccessible on return, there is nevertheless no serious rapid and irreversible decline in the claimant's health resulting in intense suffering or a significant reduction in their life expectancy.

Assessing the risk facing the claimant on return

When raising a claim, the claimant must produce evidence demonstrating that there are substantial grounds for believing that they would be exposed to a real risk of treatment contrary to Article 3. They must provide documented evidence of their medical condition, from a qualified and certified medical practitioner with responsibility for their care (and with any relevant specialist qualification), with specific details of their condition, the treatment being provided, the prognosis if treatment is sustained, the likely effects of withdrawal of treatment and the likely suitability of any alternate treatment for their medical condition.

If they claim there is inadequate or no medical treatment available in the country of return or that such treatment will be inaccessible, the onus is on the claimant to demonstrate this; therefore the application form must contain relevant and reliable evidence to support their claim. A claimant will need to show that there are substantial grounds for considering there is a real risk of a breach of Article 3, which will necessarily include evidence about lack of availability of treatment on return or lack of access to such treatment.

If you need to request further medical evidence you should usually give the claimant 28 calendar days, in non-detained cases, to reply, see [requesting more medical evidence](#).

Availability and accessibility of treatment

The claimant must provide evidence that the care and medical treatment they require is either not available in the country of return or, where available, that they would lack access to such treatment. Whilst the onus is on them to demonstrate that this is the case, the Supreme Court in [AM \(Zimbabwe\) \[2020\] UKSC 17](#) considered:

“while it is for the applicant to adduce evidence about his or her medical condition, current treatment (including the likely suitability of any other treatment) and the effect on him or her of inability to access it, the returning state is better able to collect evidence about the availability and accessibility of suitable treatment in the receiving state.” (paragraph 33)

The test to be applied requires consideration of a range of factors based on the individual facts of each case as set out in the [substantive test and procedural obligations](#). Therefore, unless the claimant has provided evidence that their condition has reached this very high threshold, you do not need to consider issues such as the availability or affordability of treatment or the impact of withdrawing treatment. For example, if the claimant states that they cannot access treatment for a relatively minor ailment, such as an illness or injury that is currently being treated by taking

painkillers such as Paracetamol, the medical condition will not meet the relevant threshold. See [refusing leave to remain on medical grounds](#).

There is no requirement to show that the claimant will receive equivalent treatment to that which they are receiving in the UK and that which is likely to be available and accessible in their country of return. Instead the relevant consideration is whether, despite the treatment that is available and accessible in the receiving country, the claimant is likely to suffer either a serious, rapid and irreversible decline in their state of health resulting in intense suffering or a substantial reduction in their life expectancy.

Where treatment is available, you will need to consider if it is also accessible to the claimant in terms of costs and location (in relation to where they live) in the country of return, and what support they would have from family and friends. Whether medical treatment and care is accessible will involve consideration, in the round, of the cost of treatment from the state, from domestic and international non-governmental organisations as well as assistance in obtaining treatment from state and private healthcare providers; support from family or friends in providing care and paying for treatment, and the claimant's own ability to afford treatment.

In assessing if treatment is accessible you will also need to consider any physical obstacles that the claimant may need to overcome to obtain treatment. For example, they may live in a rural part of the country with limited transport options but have to travel to the only hospital that offers the relevant treatment in a city, hundreds of miles away.

You will need to be alert to the fact that if they will not be able to access treatment in their home country for a reason which falls within the Refugee Convention then this might become an asylum claim, see [claims indicating Refugee Convention protection needs](#).

Where treatment is available and accessible it is unlikely that the claim will succeed unless the claimant can demonstrate that they cannot access the treatment in their particular circumstances. If you have established that the relevant treatment is not available or the claimant would lack access to such treatment in the country of return, ultimately you must consider whether the non-availability or lack of access of that treatment is likely to lead to a serious, rapid and irreversible decline in their health resulting in either intense suffering or a substantial reduction in their life expectancy such as to amount to a breach of Article 3 of the ECHR.

Obtaining medical country of origin information

Where the claimant has established their initial case, you must investigate any 'serious doubts' about whether they can be safely removed from the UK without breaching Article 3 on medical grounds. Where they have not established their initial case you do not need to consider the availability or accessibility of treatment.

To obtain medical country of origin information (COI) to establish whether medical treatment is available or material to assessing its accessibility, you must consult the relevant Country Policy and Information Team (CPIT) products.

You should only contact CPIT if the medical COI you require is not available in existing country products.

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Obtaining assurances from the receiving state

The initial burden to demonstrate a breach of Article 3 rests on the claimant. If they have not produced any reliable medical and background or expert evidence to support their claim, or if their evidence can be rebutted to dispel any serious doubts by the available medical country information, there will be no need to obtain assurances from the receiving state.

If, however, serious doubts persist, you may need to obtain individual assurances from the receiving state that appropriate care and treatment would be available and accessible to the claimant concerned to prevent a breach of Article 3. Individual cases must first be raised with your Senior Caseworker and then referred to Asylum Policy. If an asylum claim has been made, it must be ensured that [Immigration Rule 339IA](#) is not breached.

Other exceptional circumstances

Exceptional circumstances might in principle arise in other contexts, but the UK Courts have consistently made clear that the threshold is very high and have so far been reluctant to find that this threshold has been met in individual cases. If the claimant's condition or situation does not meet the Article 3 threshold, removal will not breach Article 3. You must consider each case on its individual merits and must refer a decision to grant on this basis to a senior caseworker.

The UK Courts have to date concluded that in most circumstances, a person cannot rely on Article 3 ECHR to avoid return on the basis that they require medical assistance in the UK.

Where the Article 3 test is not met, you must consider whether the claimant's rights under Article 8 of the ECHR would be breached. See [Article 8: medical cases](#).

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Article 8: medical cases

This section tells you how to consider claims when Article 8 of the European Convention on Human Rights (ECHR) is raised by a claimant suffering from a medical condition. Article 8 deals with respect for family and private life, which includes a claimant's moral and physical integrity. Article 8 may be raised where a claimant is suffering from a medical condition.

As noted by [Hickinbottom LJ in SL \(St Lucia\) \[2018\] EWCA Civ 1894](#) (at paragraph 27): "article 8 is not article 3 with merely a lower threshold: it does not provide some sort of safety net where a medical case fails to satisfy the article 3 criteria."

The focus of Article 8 medical claims is on the quality of an individual's life, as set out in the Court of Appeal case of [GS \(India\) & Ors v the SSHD \[2015\] EWCA Civ 40](#). Article 8 medical claims therefore form part of the balancing exercise which takes place when considering Article 8 claims although it should be noted that there must be a strong healthcare case before Article 8 is even engaged.

In [R \(Razgar\) v Secretary of State for the Home Department \[2004\] UKHL 27](#), Baroness Hale held at paragraph 59 that there has to be a strong healthcare case before Article 8 is engaged and even then, "a fair balance must be struck under article 8(2)".

Further guidance has been provided by the Court of Appeal in [MM \(Zimbabwe\) v SSHD \[2012\] EWCA Civ 279](#), affirmed in [GS \(India\) & Ors v the Secretary of State for the Home Department \[2015\] EWCA Civ 40](#). In these cases, the Court reiterated the principle that the ECHR does not impose any obligation on the contracting states to provide those liable to removal with medical treatment lacking in their 'home countries', and that this applies even where the consequence of removal will be that the claimant's life will be significantly shortened. In [MM \(Zimbabwe\)](#), Moses LJ stated that:

"Although that principle was expressed [in [D](#) and [N](#)] 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."

However, the Court of Appeal went on to confirm that if there are other issues relevant to the Article 8 assessment, for example, long residence or family ties, the claimant's medical condition and their treatment will be relevant to the overall Article 8 proportionality assessment:

"The only case 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 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."

This approach was reiterated in [GS \(India\) and Ors v the SSHD \[2015\] EWCA Civ 40](#), Lord Justice Laws stating:

"If the Article 3 claim fails... Article 8 cannot prosper without some separate or additional factual element which brings the case within the Article 8 paradigm".

Lord Justice Underhill stated further:

"The absence or inadequacy of medical treatment, even life-preserving treatment, in the country of return, cannot be relied upon 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."

In addition, the Courts have suggested that the fact that a claimant is a 'health tourist', that is someone whose medical condition existed before they came to the UK, and who came to the UK with the deliberate intention of seeking treatment for that same condition, is relevant to the Article 8 assessment. In these circumstances, removal is likely to be proportionate.

In summary, in most cases concerning adults, in the absence of other factors which themselves engage Article 8 for example, lengthy residence or family ties, it is unlikely that Article 8 will be engaged when considering a health case. See [application in respect of children: medical cases](#) for further guidance on Article 8 consideration as part of a medical claim involving children. However, the medical condition and any treatment being received are relevant to a holistic Article 8 assessment where other family or private life matters are raised, for example private life, long residence or family ties in the UK. This does not mean that leave should be granted in these circumstances, simply that the condition and treatment must form part of the Article 8 proportionality assessment. The relevant caselaw is [MM \(Zimbabwe\) v SSHD \[2012\] EWCA Civ 279](#) and [GS \(India\) & Ors v the SSHD \[2015\] EWCA Civ 40](#).

See also [considering a short period of leave in post-transplant cases](#). It may be necessary to grant a short period of leave to enable the claimant to access suitable post-operative care.

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Transplant cases

This section tells you how to consider cases involving organ transplants. Such cases are likely to engage both ECHR Articles 3 and 8 and will generally fall into 2 categories:

- pre-transplant – when the claimant is waiting for an organ transplant
- post-transplant – where the claimant has received an organ transplant in the UK and may be receiving follow up treatment

Pre-transplant cases

A claimant may claim that having been promised an organ transplant or having been accepted onto a waiting list for a transplant, that removal will breach their rights under Articles 3 and 8 of the ECHR. The fact that a claimant has been accepted in principle for an organ transplant is a factor you must take into account when considering the claim. In [GS & Others](#), LJ Laws stated that:

“Where there is a real possibility of a transplant in the near future, there may be a question whether ... removal from the UK before it was carried out would violate Article 3 on the specific footing that to deprive [a person] of such an imminent and transformative medical recourse amounts to inhumane treatment.”

However, as there can never be any guarantee of an organ becoming available, acceptance onto a transplant waiting list is unlikely to be a determinative factor that will lead to a grant of leave. NHS organ selection and allocation policies set out who is eligible to receive a donated organ, categorised as group 1 and group 2 patients.

This prioritises those on the transplant list who are ordinarily resident in the UK. Organs donated are first allocated to group 1 and only to group 2 if there is no suitable group 1 patient in the UK. Those who are not 'ordinarily' resident in the UK fall into the second group of eligible recipients as far as the NHS waiting list for organ transplants is concerned.

You must therefore consider the claimant's current medical condition in line with this NHS guidance, see section on high threshold [NHS transplant selection and allocation policies and guidance](#). It is unlikely that a claimant currently waiting for a transplant will meet the required threshold unless their condition has deteriorated to such a point that they are in the critical stages of their illness.

If a specific donor has been identified, for example a family member currently in the UK and the claimant has provided evidence that the transplant is likely to take place in the near future and could not take place in their country of origin; you must consider granting a period of leave to enable the transplant to take place. You must also consider whether evidence has been provided that indicates the procedure must take place in the UK. For example, if the donor is currently located in the country to

where the claimant is to be removed, there must be reasons as to why the procedure cannot take place abroad.

Post-transplant cases

The fact that a claimant has received an organ transplant will be relevant to the overall Article 8 consideration. In [Akhalu v UKUT \[2013\] 400](#) and [Okonkwo v UKUT \[2013\] 401](#)) the Upper Tribunal considered claims from those who did not meet the Article 3 threshold, concluding that they might nevertheless succeed under Article 8, identifying as a relevant factor the fact that they had received organ transplants.

The rationale for this distinction relates to the fact that in providing a donor organ, the state and the donor established an interest in the claimant remaining in the UK, in order to avoid rejection of the organ at a later date. The Tribunal also noted the low cost of anti-rejection medication compared with the cost of pre-transplant treatment and the possible consequences of removal. However, in [Akhalu](#) the Tribunal noted that the countervailing public interest in removal would outweigh a claimants' rights under Article 8 in 'all but a very few rare cases'. In [Akhalu](#), the exceptional circumstances were that they had a highly developed private life in the UK. Accordingly, those who have received organ transplants will not normally be granted leave to remain in the UK solely to access ongoing medical treatment.

However, in deciding whether to grant a period of leave and the duration of that leave you must consider the specific factors relevant to transplant cases, for example, the availability of anti-rejection medication, ability to follow life style advice, access to medication and availability of healthcare and support abroad. In addition, you must take into account all other matters relevant to the Article 8 assessment – including, for example, whether the claimant is here lawfully or unlawfully, whether they are a health tourist and the extent of their family and private life in the UK.

Considering a short period of leave in post-transplant cases

Post-transplant cases are unlikely to meet the high threshold for Article 3 as claimants must produce evidence demonstrating that there are substantial grounds for believing that they would be exposed to a real risk of treatment contrary to Article 3. It is also likely that maintaining a transplant (through anti-rejection medication) will require less treatment over time and is significantly less expensive than, for example, dialysis. You must therefore consider whether the ability to access the necessary medication and support abroad will be easier to obtain as the claimant's condition improves. It may therefore be appropriate to grant a short period of leave, with a view to removal when the claimant's condition has stabilised. See [granting leave to remain on medical grounds](#).

Certifying a decision in transplant cases

It is highly unlikely that certification will be appropriate in any transplant case given the complex nature of the issues involved. If the claimant has been accepted onto the transplant list by the NHS or they have received an organ transplant the case must not

be certified. In any other case where you are considering certifying the decision on a transplant case, this must be approved by a senior manager at no lower than Grade 7 and Asylum Policy must be informed.

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Mental health cases

In [RA \(Sri Lanka\) v SSHD \[2008\] EWCA Civ 1210](#) (paragraph 49), the Court of Appeal held that in Article 3 cases, the same principles apply to mental illness and suicide cases as they do to physical illness cases. Neither the European Court of Human Rights in Paposhvili, nor the Supreme Court in AM (Zimbabwe) considered Article 3 mental health medical claims and so did not comment on whether RA (Sri Lanka) was still correct. The principles in AM (Zimbabwe) therefore apply to cases of mental illness and/or suicide risk. It is necessary to consider whether appropriate treatment to reduce the risk of suicide is available and accessible in the receiving country. Treatment may not be accessible if the person is too traumatised by previous hostile actions of the receiving state to be able to access it and has no family support to help them to do so (see [Y and Z v Secretary of State for the Home Department \[2009\] EWCA Civ 362](#)).

Specific factors to consider in mental health cases

The case of [Bensaid v UK \[2001\] 33 EHRR 205](#) established that the same principles as those set out in relation to [Article 3](#) and [Article 8](#) medical cases apply where the claimant suffers from mental rather than physical ill-health. For example, a claimant suffering from mental illness may be able to establish a claim where their illness carries with it a risk of death. Such risk will usually arise from their projected suicide, although it could also arise from their illness, rendering them incapable of caring for themselves or likely to expose them to danger. In addition, Bensaid confirmed that a mental health case may engage Article 8.

In general, whilst mental health cases give rise to particular matters which you will need to consider, in line with this guidance, it is important to keep in mind that the threshold for a breach of Article 3 of the ECHR remains the same.

Cultural and social issues

If relevant, you must consider how claimants with mental health issues are treated by their wider community in their country of origin. For example, in some cultures mental health issues are perceived in a highly negative manner leading to rejection by the family and the community. Where such matters are raised, you must take this into account as part of your assessment of the claim, bearing in mind the importance of family, community and social support in the management of mental health. You must also be alert to the possibility of protection claims arising because of mistreatment in their country of origin due to the claimant's mental health issues, including on the basis of membership of a particular social group. See [claims indicating Refugee Convention protections needs](#).

Care and treatment available

As with all medical cases claimants must produce evidence demonstrating that there are substantial grounds for believing that they would be exposed to a real risk of treatment contrary to Article 3. You will then need to consider what treatment is available and accessible to the claimant in the receiving state and what the consequences of any reduced level of treatment will be for the claimant on return. In some countries, the treatment provided for people suffering from mental health problems would be regarded in the UK as inappropriate. This will be relevant to the Article 3 assessment. However, in considering these matters you must bear in mind the very high threshold required to give rise to a breach of Article 3 as set out in the [substantive test and procedural obligations](#) and the required considerations including accessibility of treatment. See guidance on humanitarian protection and considering human rights claims.

Suicide and self-harm cases

If a claimant claims their removal will give rise to a real risk of suicide or self-harm, that claim may engage the UK's obligations under Articles 3 and or 8 of the ECHR. A claim that removal will lead to a risk of suicide or self-harm does not necessarily mean the claimant cannot be removed or that leave should be granted. However, such a claim must be carefully considered and the appropriate safeguarding measures must be taken.

Whilst the same general principles apply to cases involving physical or mental illness, separate considerations also apply where a claimant claims to be at risk of suicide. In particular you must consider the level of risk arising, particularly where the risk flows not from a mental health illness but from a fear of what may happen to them on return and steps that can be put in place to mitigate that risk at every stage of the removal process.

The key case on the approach to be taken in the context of suicide claims is [J v SSHD \[2005\] EWCA Civ 629](#). In that case, the Court confirmed that an Article 3 claim can in principle succeed in a suicide case. The case also emphasised the importance of identifying the facilities that the removing and receiving states have to reduce the risk of suicide. The Court divided the process of return into three stages:

- whilst in the UK on learning that removal will take place
- in transit
- on arrival in the destination country

The Court held in J that in cases where suicide may be an issue, there must be an assessment of 'real risk' which is summarised as the 6 point test. If that 6 point test is amended to take into account later case law it is as follows:

- 1) There must be an assessment of the severity of the treatment it is claimed would be suffered. There must be a minimum level of severity and the severity will depend on all circumstances of the case. The 'ill-treatment' must 'necessarily be serious' (paragraph 26)

- 2) There must be a causal link between the act of removal and the claim of inhumane treatment which would be suffered (paragraph 27). The claimant must provide medical evidence. Anxiety or depression, for example, do not necessarily mean suicidal. The claimant must show increased risk of suicide abroad, if already at risk of suicide in the UK.
- 3) For claims that the suicide or self-harm will occur abroad, the threshold is particularly high, and it is even higher when the alleged inhumane treatment the claimant will suffer is not the direct or indirect responsibility of the receiving state's authorities but results from a naturally occurring illness, physical or mental (paragraph 28)
- 4) An Article 3 claim in a suicide case can succeed in principle (paragraph 29). This reflects the high threshold but that a claim of this kind could succeed in principle
- 5) It is very important to establish if the fear on return is objectively well founded. If not, it will weigh against the real risk (paragraph 30). However, this is not necessarily determinative, especially if the subjective, but unfounded fear, stems from past mistreatment by the receiving state and there are no family members, or other support in the receiving state to help the person overcome that fear (see *Y and Z v SSHD* below)
- 6) Effective mechanisms to reduce the risk of the removing and or receiving states are also very important in evaluating real risk (paragraph 31). It is now clear, following [AM \(Zimbabwe\)](#), that such mechanisms must be both available and accessible to the claimant.

It will almost always be the case that the risk of a claimant's suicide on learning that removal will take place and during transit to the receiving state can be managed by UK medical authorities, together with the support structure that the claimant has in place in the UK. This was restated in [Tozhlukaya v SSHD \[2006\] EWCA Civ 379](#). Similarly, providing medical care to reduce the risk of suicide is available and accessible to the claimant in the receiving state, this will generally be deemed sufficient. Care does not have to be available universally, or even widely. This is particularly so if the claimant has family in the receiving state, able to assist them in accessing such care as is available and able to provide family support in general. This reasoning reflects that applied in broader categories of medical cases.

An additional factor to be considered arises in cases in which the claimant is not delusional and their risk of suicide arises from an unfounded fear of what will happen to them on return. Of course, if there is a continuing risk of torture, the claimant will have a protection claim. With that in mind, in [J](#), the Court concluded that the fact that the claimant's fears were not objectively justified was important. They upheld the decision of the tribunal below, who had pointed out the possibility that J might, on return, "take stock by reference to objective realities", such that the risk of suicide would no longer arise.

In [ST \(Sri Lanka\) & CT \(Sri Lanka\) v SSHD](#) (also known as [Y and Z v Secretary of State for the Home Department \[2009\] EWCA Civ 362](#)) the Court of Appeal added an ancillary statement to this principle:

“That what may nevertheless be of equal importance is whether any genuine fear that the appellant may establish, albeit without an objective foundation, is such as to create a risk of suicide if there is an enforced return”.

The facts in Y and Z were somewhat extreme. It should be noted that matters of importance in the case were (a) that the claimants had been tortured by the Sri Lankan authorities in Colombo (where the only treatment was available) and would feel unable to access that treatment, and (b) the claimants’ family in Sri Lanka had all died in the 2004 tsunami. Accordingly, it was felt that Y and Z would be unassisted in accessing the care available in Sri Lanka. You must therefore consider, as part of your analysis (a) whether there is some reason why the returnee would not be able to access treatment without support on return and (b) the level of support that may be available to a claimant on return to their country.

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Considering medical evidence

This section tells you how to consider medical evidence submitted in support of the application.

It is the responsibility of the claimant to provide acceptable, accurate and up-to-date medical evidence to support their application. They must provide evidence about their current state of health and may also provide evidence as to the likely effect of return on their state of health. You must assess this evidence when you consider their medical claim but you are not expected to have any medical expertise. If you need more guidance, you must first ask a senior caseworker who may in turn refer your enquiry to the Asylum Policy team.

Acceptable medical evidence

You must consider all the medical evidence you receive. For the purpose of considering medical claims, a medical report must be:

- printed on letter-headed paper showing:
 - the address and contact details of the hospital or NHS trust, and
 - the name and contact details of the consultant (note, private practitioners or medico-legal report writers may not be linked to a hospital or trust)
- an original document (hard or electronic version), not a photocopy or a faxed document
- dated within 3 months of the date received by the Home Office (note, older evidence may: provide important context or information about the duration of an illness; confirm a person has a permanent and/or untreatable condition; be the most detailed medical report with later information providing an update on the situation)
- written and signed by a qualified health professional who must have seen the claimant with the medical condition in person (note, this may be via digital appointments) or is the clinician responsible for their care
- accompanied with the medical practitioner's CV setting out their qualification experience and expertise (note, important medical evidence provided to the Home Office may be from clinician to clinician (for example, a memory clinic may send a report to the person's General Practitioner (GP) copying them in) or from clinician to patient and so may only include the person's name and job title. It is relevant to expect a medico-legal report writer who is presented as an expert to set out that expertise in terms of their training, experience and/or research)

For this purpose, the definition of a qualified health professional is a clinician who is primarily responsible for the claimant's day to day treatment. They must be registered with the General Medical Council (GMC). If not registered with the GMC at the point at which their evidence is examined by the Home Office, the reason for this needs to be clarified (for example they may have retired in the intervening period).

You can check if the clinician is registered on the [list of registered medical practitioners](#). Note, evidence may be submitted by GPs, who deal with a vast majority of medical issues, and other healthcare professionals such as clinical psychologists and specialist nurses. Those, who are not doctors, are unlikely to be regulated by the GMC.

Where the medical evidence does not meet these standards, you have discretion to allow the claimant an opportunity to submit acceptable medical evidence before you make your decision. You should usually allow 28 calendar days, in non-detained cases, for the claimant to provide the evidence, but this could be longer in individual cases where there is clear evidence that, for example, a specialist or expert medical report is being produced. If the evidence is not submitted within the agreed time period, you must make your decision based on the information available, which will be a refusal where there is no medical evidence to support the claim.

Evidence of post-traumatic stress disorder

When the claimant has been diagnosed with post-traumatic stress disorder (PTSD), the diagnosis and medical report must have been made and written by a consultant mental health specialist. When the medical evidence does not meet these standards, you must give the claimant an opportunity to send acceptable medical evidence, before you make your decision. GPs may, for example, make a diagnosis but it is likely to require an individual treatment plan to be developed with a mental health specialist.

Medico-Legal Reports

You may see Medico-Legal Reports (MLRs) produced in support of a medical claim. MLRs can serve a number of purposes, for example (and non-exhaustively) to diagnose a condition or deal with prognosis; assess a cognitive impairment, developmental disorder or learning difficulty; or assess treatment needs and risk issues. An MLR that documents torture, cruel, inhumane or degrading treatment or punishment must have been compiled in line with the standards set out in the medical evidence Asylum Policy guidance. You must keep in mind that a claim to have suffered torture, cruel, inhumane or degrading treatment or punishment may amount to an asylum claim. It may be appropriate to inform the claimant that any protection claim will not be considered unless or until they make a claim in person in line with the process set out in '[claim asylum in the UK](#)' or '[submit new evidence to support your asylum claim](#)' on the GOV.UK website.

This guidance does not cover considering medical evidence in the context of making detention decisions, the [Adults at risk in immigration detention](#) policy guidance must be followed for those decisions.

Requesting more medical evidence

It is reasonable to expect most claimants who apply on medical grounds to be able to submit acceptable medical evidence with the initial claim. However, the evidence

may lead you to ask additional or alternative questions. Any such follow-up questions must be appropriate to the individual circumstances of the claim.

If you need to request further medical evidence you should usually give the claimant 28 calendar days, in non-detained cases, to reply. You must make this timescale clear and explain that where they think they may face difficulty meeting this deadline, they must contact the Home Office within the 28 days to give:

- the reason or reasons for the delay
- the date when they expect to provide the evidence requested

You must not delay consideration of the application indefinitely. If you do not receive a satisfactory response within the time agreed, you must make your decision based on the evidence available.

When the claimant has representatives, it is the claimant's responsibility to either keep in touch with the representatives, or to notify the Home Office if they are no longer represented, as appropriate. If the claimant fails to do so, you must not accept it as an exceptional circumstance warranting extra time. However, it is important to consider if there any exceptional circumstances which may mean the claimant is unable to notify the Home Office accordingly, for example but not limited to, due to; a particular disability; being detained under a section of the Mental Capacity Act; or if they lacked capacity to make such a decision.

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Outcomes and decisions

This section tells you how to grant or refuse applications for permission to stay on human rights (medical) grounds.

Refusing leave to remain on medical grounds

If a claimant does not meet the threshold for a grant of leave on the basis of their medical condition, you must refuse their application. Your reasons for refusal letter (RFRL) must address all of the issues raised by the claimant and reflect how you considered the individual merits of the claim. It must also properly reference the sources you used to reach your decision. For Article 3 claims on medical grounds the [substantive and procedural test](#) must be followed.

Refusing someone previously granted leave

When the last period of leave was Discretionary Leave (DL) or leave outside the rules (LOTR) on human rights medical grounds, your RFRL must:

- explain why the claimant no longer continues to qualify for leave
- include reference to any other appropriate consideration, for example, leave to remain under the Immigration Rules and leave under Article 8 (medical) of the European Convention on Human Rights

Granting leave to remain on medical grounds

If the claimant meets the threshold required, you should normally grant limited leave to remain in line with the policy guidance on discretionary leave. In exceptional cases or where the claimant has raised specific reasons why, consideration of a longer period of leave may be appropriate. See DL guidance on granting longer periods of leave. In some cases, you may wish to grant a shorter period of leave, for example for post-operative care. See [considering a short period of leave in post-transplant cases](#).

Referring the case before granting

As the tests for granting discretionary or indefinite leave under human rights (medical) grounds are very high, granting under this policy is rare. If you decide to grant such a case, you must refer the case to a senior caseworker before you do so.

Granting limited leave to remain

If you decide an application meets the requirements for leave to remain based on a medical condition, you must grant DL.

Length of grant

You may grant DL usually up to a maximum of 30 months (two and a half years). It must not exceed life expectancy by more than 3 months, and you can grant leave in line with the length of treatment if it is appropriate.

Conditions

You must grant DL on code 1A, which means that the claimant will have access to mainstream benefits.

Dependants

You must grant eligible dependants who were listed on the application form leave in line with the main claimant on code 1A conditions. A partner and children, under the age of 18, can be included as dependants.

Dependants who are overseas

There is no provision to grant leave to enter to dependants overseas on account of the claimant being granted DL, though any dependants could choose to apply to come here independently under the Immigration Rules.

A claimant granted DL is not entitled to:

- bring their partner or children to the UK
- act as a sponsor to bring other relatives to the UK
- family reunion under the refugee family reunion rules

Granting further periods of limited leave or indefinite leave

Given the high threshold and nature of cases granted leave on the basis of a medical condition, it should only be in exceptional cases that a further period of limited leave is required, following the initial grant, and it should be extremely rare for an claimant to have accrued the relevant period of leave necessary to meet the requirements for a grant of ILR.

Further periods of limited leave

Any application by a claimant for a period of further leave must be considered in line with this policy, including the relevant threshold. Where a claimant has previously been granted DL, the fact that they may continue to have a medical condition will not of itself be sufficient to satisfy the requirement that the previous circumstances that led to the grant of leave are continuing. You must consider any subsequent application for further leave in light of the relevant facts that apply when the decision is made.

Medical issues that do not meet the relevant threshold under Article 3 may still be relevant to any Article 8 consideration.

Granting settlement

If you are considering granting immediate settlement in cases where the claimant has not previously been granted leave on the basis of a medical condition, you must refer to the DL guidance on granting longer periods of leave.

If following a period of limited leave to remain, the claimant applies for settlement, the application must be considered in line with the Immigration Rules. Some people may be excluded from applying for settlement due to their:

- character, conduct or associations or they are a threat to national security
- criminal record
- security issues

However, when a claimant has held DL for 10 years (or 6 years under the transitional provisions of the DL policy) and continues to qualify on the same basis as the last grant of DL, you would generally grant ILR unless there is a compelling reason not to do so. You must refer to the guidance on discretionary leave for consideration of ILR applications.

Case management notes

Your case management notes must accurately reflect the factors you have considered in making your decision to grant or refuse.

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