

After the Acid Test: Safeguarding Rights in Care Settings after the Overturning of Cheshire West

National Mental Capacity Forum Webinar
Wednesday 24th June 2026

- The Webinar will begin at 12pm
- We are a large group, so cameras and microphones of delegates are disabled
- Please use the Zoom Q/A function to pose questions; we will address as many as we can
- **A recording and a copy of all slides will be made available to all delegates.**



From Cheshire West to Northern Ireland

Redefining Deprivation of Liberty

**Ben Troke – Health and Social Care Solicitor-
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Background

Mental Capacity Act – autonomy and paternalism

- Best interests decisions where P cannot decide
- But proportionality: – the more intrusive, the greater the need for safeguards. MCA s5, s6.
- Article 5 ECHR – the right to liberty. Where someone is DoL, there needs to be a due legal process, and a right to challenge.
- That legal process is usually the Deprivation of Liberty Safeguards (“DoLS” – where they apply), or an application to Court.
- MCA is our framework for making the best interests decisions that may bring restrictions
- DoL/S is our legal framework for extra the scrutiny of the restrictions (not the only safeguards)
- Get the MCA right first and foremost

We need to know what a DoL is!

1. Objective (confinement)
 2. subjective (no valid consent)
 3. imputable to the state (always?)
- 2009 – “There is no simple definition of a DoL”
 - 2014 – the Cheshire West “acid test” for confinement – continuous supervision and control and not free to leave
 - Taken for granted there’s no consent to the DoL because P lacks capacity for those decisions
 - Traded clarity for breadth – catching too many people?
 - Attorney General of Northern Ireland’s application



AGNI decision (2 June 2026): Cheshire West was wrong

- The “acid test” is too crude a test of objective confinement.
- It needs to be multi-factorial
- The things Cheshire West discounted ARE in fact relevant –
- Purpose, reasons, context, objection etc
- Coercion is an essential element
- In context –
- Domestic home is treated differently – something extreme is needed before it might be a DoL
- Hospital for physical medical treatment is treated differently – going further than Ferreira.
- If in doubt – how much is it like the “paradigm” prison cell?
- Liberty means **physical** liberty
- It was wrong to discount the subjective element
- People’s wishes and feelings should be given weight
- “Valid consent” for Article 5 purposes is different to consent to treatment or care
- So – someone can show they are “happy” with the restrictions and this can be “valid consent” even though P lacks capacity for the decisions about the care / treatment / accommodation
- Introducing “incapacitous consent”.
- But medication with effect of suppressing objection needs to be seen as a red flag.



Applying this

- MiG was not DoL
- MeG was not DoL
- P (Cheshire West) probably not DoL
- SM (12) – Lieven J – was not DoL
- Patient who is minimally conscious / in “catatonia” is not DoL
- Patient who is stopped from leaving hospital while confused by their treatment
- HL was DoL (but that’s mostly about the psychiatric inpatient setting)
- Very few people in hospital for medical treatment will be DoL unless: there is likely to be an argument about the treatment itself anyway, or they are delayed discharges?
- Very few people in their own home will be DoL, and certainly none of those who would have been suitable for Re X.
- What room now for Re X / COPDOL11?
- What need now for LPS?
- This is ok – the DHSC “promise” (fairytale?) of other safeguards



Now what

- Get the MCA right – first and foremost
- This is not about changing the substance of anyone's care
- Current (and pending) DoLS authorisations / court orders will need review
- But does not mean that anyone is (newly) “unlawfully DOL”
- New roles will be different – wider issues for confinement, and much more focus on the subjective issue – regear teams / resources, and skill sets / training
- There will be those who mourn the end of Cheshire West – but don't idealise it
- There are risks to mitigate – eg “incapacitous consent” being misunderstood and applied to care and treatment
- They can be mitigated – and we should start with “confinement?”.
- There will be fewer cases, but more complexity.
- Uncertainty and subjectivity in practice will lead to inconsistency, and will need benchmarking
- Don't panic!
- More guidance will come – beyond “ask AGNI”!
- There will be leeway while we learn
- Focus on getting the MCA right.



**How are local authorities
responding to the challenges and
opportunities afforded by the AGNI
judgment?**

Richard Orson

**Principal Social Worker, North Somerset Council,
Co-chair of South-West PSW Network**



What the judgment has meant for local authorities – the immediate aftermath

- From clarity to confusion in an instant!
- A state of shock and, for some, mourning for Cheshire West
- A period of adjustment
- New legal definitions and concepts for practitioners to apply to people's real lives
- New challenges in ensuring consistency in decision making
- Collaboration locally, regionally and nationally to decide how to respond.
- Divided professional opinion – an opportunity to refocus resource vs an erosion of rights – how to balance the two perspectives?



Some key challenges

Upskilling the workforce

- Increasing confidence and ability in applying concepts which are open to subjective interpretation, e.g. the “multifactorial test” and determining “valid consent”.
- Are we equipped to safeguard in “less intrusive ways” as per paras 10 and 141?

The risk of under-protection - mitigating risks for specific groups

- Removal of independent checks, advocacy and legal aid for many - [the charities' response](#), e.g.
- People who self-fund their care not subject to Care Act reviews
- People who don't have family and friends to represent them
- People who appear compliant but may struggle to express their objection
- People in community settings where “relative normality” means they're unlikely to meet the multi-factorial test
- Compliant incapacitated patients receiving mental health treatment in hospital settings

Practical considerations

- Resources required to review waiting lists, existing authorisations, current allocations, community dols, s.21A challenges etc
- Resources required to update relevant training, policy and guidance and leaflets
- Strategic uncertainty and workforce planning – LPS and DoLS Teams resource



Plunged into chaos or a period of adjustment? – legal uncertainty, confusion and blurred boundaries

Multifactorial Test

- Loss of clear threshold
- Guzzardi “plus” – A coherent test or a broad list of indeterminate factors?
- Unclear how much weight to apply to each factor or when the DoL threshold is met
- Blurring of the objective and subjective elements
- Reintroduction of “relative normality” as a factor
- A Gilded Cage is no longer a cage - understanding the “prison paradigm”
- New test is more open to subjective interpretation than the “acid test” - how to ensure consistency?

Valid Consent

- New concept for practitioners, distinct from mental or legal capacity (but only for Article 5)
- Blurs lines between capacity, tacit consent, assent and informed consent
- When, if ever, can the absence of objection amount to valid consent?
- What constitutes “a basic awareness” of someone’s situation or care arrangements?
- How do we know if someone is broadly “happy” with arrangements or merely resigned to them.
- What about people who are “institutionalised” or can’t communicate their objection?
- Can people object, but objective factors mean they’re not deprived? – “relative normality”

How can we improve supported decision-making processes for people who lack mental capacity?



Opportunities for Local Authorities

- Cheshire West wasn't safeguarding people anyway - the people who were not objecting already make up a significant proportion of the backlog.
- Some argue that the judgment is an opportunity to return to common sense and to refocus resource where it is most needed - see [Lorraine Currie's article](#) in Open Justice
- Some clarification in AGNI is helpful – e.g. paras 142 – 145 re unconscious people, people without “physical liberty”, people receiving treatment for serious health conditions etc.
- We can now focus on developing how we robustly apply other legal frameworks and safeguards – improving our knowledge and application of the HRA 1998, MCA 2005 and Care Act 2014 and its guidance.



Guidance so far ...

DHSC

- Advises us to share ruling with organisations /staff
- Published [Provisional Interim Guidance](#) (15 June 2026)
- Review policies, protocols, websites and public-facing leaflets.
- What should be considered in a multi-factorial assessment.
- Examples of objection (including physical restraint, covert meds) which point towards a DoL.
- Determining someone's wishes and feelings.
- Suggests **MAs refer where there is any doubt**
- Advises to review asap , but crucially that ***leaving the authorisation in place pending review does not mean the person is being unlawfully deprived of their liberty.***
- [Chapter 2 DoLS Code](#) recommended as useful starting point re objective element as pre-Cheshire West.

ADASS

- Originally urged “[a cautious approach](#)”.
- Subsequent [update note](#) issued following DHSC's guidance
- States they are actively working with national DoLS Lead network to develop a “**priority / review tool.** “
- Emphasises importance of starting with a multi-factorial assessment rather than valid consent

CQC

- Limited guidance for providers
- MAs to Consider DoLS requirements case by case
- Valid consent only for article 5, not care and treatment
- Continue to apply MCA 2005

Further guidance anticipated from the DHSC ...



So, what's needed next?

- Clearer, more detailed guidance (and ideally updated Codes of Practice)
- Proportionate, consistent and legally defensible ways of reviewing people on DoLS waiting lists, DoLS authorisations and community dols.
- Updated DoLS Forms ([see for example those from West Midlands ADASS](#))
- Clarity on some of the legal uncertainty arising from the ruling – though this may need subsequent case-law
- Developing our systems, upskilling our workforce and holding each other to account to ensure that the judgment doesn't lead to *'the biggest rollback of disability rights in a generation'* as charities fear.



Elephants, Mosaics and Hammers Reflections on *Re AGNI*

Dr Lucy Series, Associate Professor in Social Care
Law and Policy

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June 2026



Valid Consent in principle

Re AGNI establishes that a person who 'lacks mental capacity' can give a legally valid consent to their confinement

This is an argument that I, and others, have made, drawing from a disability rights tradition that is linked to article 12 of the CRPD

It is anchored in the belief that regardless of a person's 'mental capacity' we should do our best to understand their 'will and preferences' and give that legal effect

The valid consent approach recognizes that even people with significant cognitive disabilities are capable of enjoying the right to liberty.



The elephant in the room



Valid consent and safeguards

However! Article 12 CRPD also calls for **proportionate safeguards on any measures relating to legal capacity**, to ensure this really does align with the person's 'will and preferences'

Some ECtHR authorities *also* talk about the importance of valid consent to confinement being 'objectively established' using 'fair and proper procedures' (*Stankov v Bulgaria, M v Ukraine*)

Yet the ruling in *Re AGNI* does not require any formal procedural safeguards to confirm that a person has given a 'valid consent'

(That does not mean that we cannot still require them though...)



The problem with MEG

Applying this approach to the individuals in *Cheshire West* the UKSC in *Re AGNI* concluded that MIG and MEG were both 'validly consenting'

MIG was described across all judgments as happy living with her foster mother, and was never restrained or sedated

However MEG was described by the UKSC in 2014:

- as wishing she still lived with her foster carer
- experiencing restraint for 'occasional outbursts of challenging behaviour towards the other three residents'
- Prescribed Risperidone, which the UKSC (2026) described as 'tranquilising' medication of the kind capable of suppressing objections

There is no robust analysis of the factors pointing in the other direction.



The new 'multifactorial' objective test

'the assessment is multifactorial, with account taken of a whole range of factors including the type, duration, effects and manner of implementation of the measure in question... no single factor is determinative.'

Re AGNI

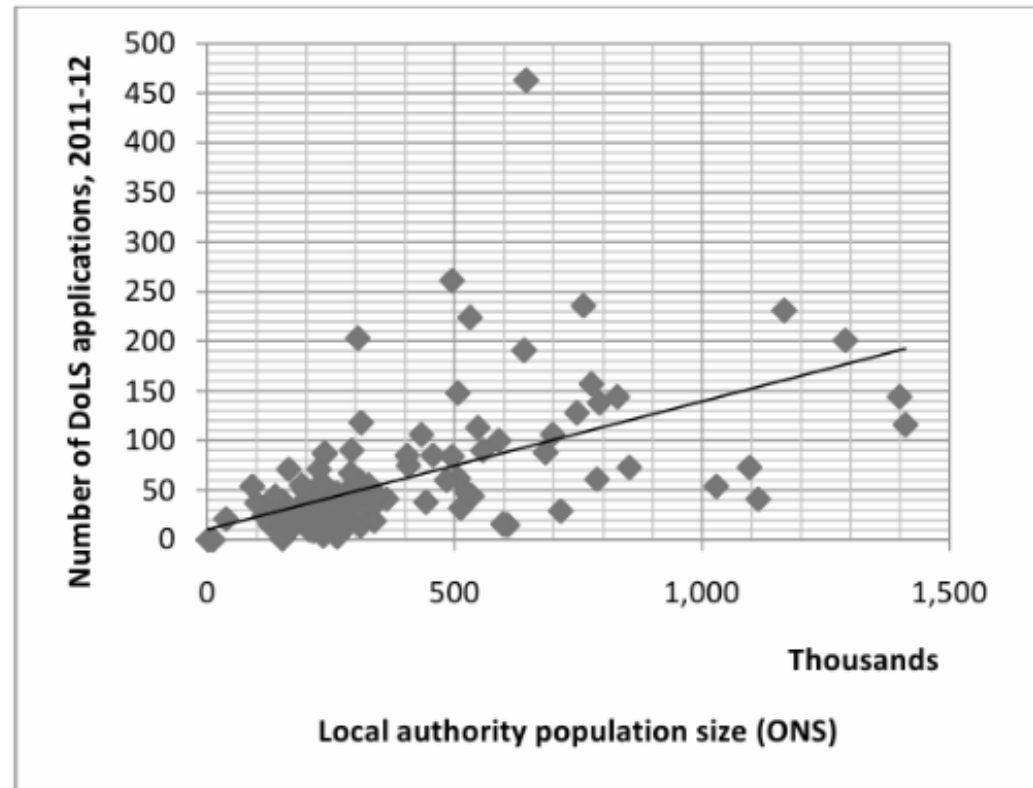


Building mosaics, not spotting elephants



Variation in DoLS rates before *Cheshire West's* 'bright line rule'

Figure 6 DoLS application rates by local authority, 2011-12 (England)



The new paradox of the will

'Incapable' of enjoying liberty	People who are 'catatonic... and unable to express any view at all about what should happen to them'. They are either unconscious or 'so profoundly disabled that they cannot conceptualise leaving let alone physically achieve this'. They can neither move their own body nor 'request' that others move it for them. (Exception for cases where the person <i>would</i> object, or they were deliberately medicated into unconsciousness)
Capacity for valid consent:	' a basic level of awareness and consciousness of their living arrangements that is sufficient to enable them to know and communicate whether they are happy or unhappy with them', 'a tacit positive indication of wishes and feelings showing contentment with the arrangements can be ascertained'
Capacity for 'deprivation of liberty'	'they may nonetheless be sufficiently aware of the circumstances... as to be able to register whether they are happy or unhappy with those circumstances and to enter protests against their treatment if they are unhappy with them '; 'If an individual objects to the arrangements, this is likely to result in conflict . There may be arguments , attempts to leave a particular place, expressions of a wish to leave, or conduct showing a wish to leave.'

Mrs Justice Parker describing MIG and MEG: 'neither appears to have the capacity to conceptualise any alternative unfamiliar environment'



Maslow's Law of the Hammer

- “it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail”
- What are the problems we are trying to solve?
- Is article 5 the best tool we have for solving them?
- Where next for ‘safeguards’ – beyond article 5?



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Q&A and Reflections

Prof. Wayne Martin

Ben Troke

Richard Orson

Dr. Lucy Series



Closing Remarks

Margaret Flynn

