Deprivation of Liberty
Understanding *AGNI* [2026]

Understanding *AGNI* and top tips for providers

On 2 June 2026, the Supreme Court handed down its judgment in *A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 [2026] UKSC 16 ("**AGNI**").*

The judgment has immediate effect.

What was the situation under *Cheshire West?*

Under *Cheshire West* [2014] a person was deemed to be deprived of their liberty if they lacked capacity to consent to their care or treatment arrangements under the Mental Capacity Act 2005 ("**MCA 2005**") **and** if the objective "acid test" was met.

The "acid test" element was satisfied if a person was:

(a) subject to continuous supervision and control; and

(b) not free to leave

How does Article 5 ECHR apply?

The MCA 2005 defines deprivation of liberty by reference to its meaning in Article 5(1) of the European Convention on Human Rights (ECHR) which concerns physical liberty. In line with Article 5, a person is deprived of their liberty (and DoLS authorisations are required in care settings) if three elements are satisfied:

1. **Objective element** - the person is confined to a particular restricted space for more than a negligible period of time.

2. **Subjective element** - there is no valid consent to that confinement.

3. The **state is responsible** for the confinement.

What is the situation post *AGNI*?

The Supreme Court held that the *Cheshire West* objective "acid test" is not sufficient by itself to determine if a person is deprived of their liberty. There is an overlap between the objective and subjective elements. Under *AGNI*, the following must now be considered:

- **Multifactorial assessment** - look at a range of factors, not purely whether a person is subject to continuous supervision and not free to leave. Consider the nature and degree of restrictions including the type, duration and effects. When considering whether an arrangement objectively amounts to a "confinement", the "relative normality" of the care placement is also a relevant contextual factor.

- **Valid consent (absent mental capacity) -** Valid consent for the purposes of the subjective element of the Article 5 ECHR (right to liberty) test is not the same as decision-making capacity under the MCA 2005. It is a lower threshold based on a person demonstrating a basic level of awareness of their circumstances and communicating acceptance of their care arrangements. A person can give valid consent (verbally, non-verbally or behaviourally) if they are *"conscious of their environment"* and have a "*basic understanding of their living circumstances*". Their agreement can mean that there is no deprivation of liberty.

- **Borderline cases** – Valid consent should not be confused with passive acceptance. In borderline cases where there is "*serious doubt"* no inference of valid consent should be drawn.

Top tips - what should providers do now?

Whilst awaiting official guidance on the application of the judgment from the Department of Health & Social Care, providers should consider the following matters:

- **MCA 2005 principles apply in full**

Regardless of whether a deprivation of liberty exists, MCA 2005 principles apply in full. If someone lacks capacity to decide a matter, consent cannot be inferred and a best interests decision is required. Decisions must remain necessary, proportionate and in the person's best interests. This should be clearly documented.

- **Review existing arrangements**

Continue to care for service users in line with their care plan. The formal DoLS authorisation authorised the arrangements which were already in place. CQC expects providers to proactively review existing deprivation of liberty arrangements to ensure that they are current but the arrangements themselves do not necessarily need to change.

Providers should demonstrate that an individual's wishes and feelings have been actively sought and that there has been consideration as to whether the person appears to be content or is objecting. This should be clearly documented in their care plan.

Consider introducing a tracker which shows that existing DoLS authorisations have been reviewed post *AGNI*. Equally as important, show that they continue to be reviewed regularly and remain necessary, proportionate and person-centred.

Standard DoLS authorisations need to be Part 8 reviewed. Providers should request Part 8 reviews from Best Interests Assessors to assess whether a person's care arrangements and restrictions still meet the legal criteria for detention.

- **New deprivation of liberty arrangements**

With regards to any new cases where deprivation of liberty arrangements need to be considered, regard will need to be had to the *AGNI* judgment. Whilst we await official guidance, it is probably sensible for providers to continue making DoLS referrals to the local authority. Once official guidance has been published we should have a clearer idea about the correct procedure to follow.

- **Advocacy**

Advocacy remains essential for service users.

An IMCA is legally required to be appointed within 8 weeks of admission to a care home if the person lacking capacity for the specific decision has no LPA or deputy with relevant authority and no other appropriate person to consult. Attempts to contact the local IMCA service and any reasons for delay in appointing an IMCA should be recorded.

In accordance with the Care Act 2014, local authorities are expected to review care and support plans at least every 12 months to ensure that care remains appropriate, effective, and compliant with the wellbeing principle. Providers should request these reviews from the local authority if they have not taken place.

- **Staff training**

Inform staff about the judgment making them aware that the previous *"acid test"* should be disregarded and there is now a focus on a multi-factorial assessment and valid consent.

Explain to staff that we are awaiting official guidance which should clarify matters soon.

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