# What the Supreme Courts Deprivation of Liberty judgment means for social care

Chair: Gerard Crofton–Martin  Interim CEO SCIE

Speaker: Ben Troke  Weightmans  LLP

# About SCIE

- Independent not-for-profit social care charity, working with a wide range of partners and people with lived experience
- >20 years collaborating and innovating to improve adults and children's lives
- Expert staff: registered social workers, social care practitioners, local authority professionals, researchers, training experts
- Offer covers wide range e.g. digital innovation, pathway redesign, local government reform, CQC support
- DHSC - deliver improvement support for councils' social care and public health services, working with Partners in Health and Care (LGA and ADASS)
- Co-production with people with lived experience of  social care underpins and informs what we do, enabling us to recommend best practice in social care

scie social care institute for excellence

## We provide

scie consultancy

Innovative consultancy – your not-for-profit partner, working with you to identify and implement improvements

scie insights

Research, evidence and policy insights to drive improvements and innovation, and influence national policy and practice

scie training

Expert bespoke online and face-to-face learning and development, including safeguarding, co-production and strengths-based approaches

scie resources

Extensive guidance and tools to support best practice, co-production and innovation

**Contact consultancy@scie.org.uk to find out how we can help.**

# Agenda

15.00 Introductions

15.05 Main speaker

15.35 Q& A

15.55 Concluding remarks & feedback

**Please keep your microphones on mute and use the Q & A to post questions**

Weightmans

# Weightmans

## Deprivation of liberty, post AGNI SCIE

15 July 2026

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Weightmans

# Our Healthcare Practice

## Our people

**150+**
specialist healthcare lawyers

**180+**
local government and public sector lawyers

## Our clients

**166** NHS Bodies
NHS Trusts, ICBs and national bodies (including NHS Resolution, NHS England)

**242** Local & National Government Organisations
Local and regional councils, central government departments and government funded bodies.

**200+** Primary Care Practices
GP surgeries, pharmacies and dental practices.

**140+** Private and Independent Health and Care providers
Care homes, charities, healthtech companies and private secondary care providers.

**15** Medical Defence Organisations
Royal Colleges, medical insurers and practitioner membership bodies.

## Instructing us

We are appointed to the main national NHS frameworks including:

NHS Resolution

NHS North of England Commercial Procurement Collaborative

NHS Commercial Solutions

NHS Shared Business Services

HEALTHTRUST EUROPE

## Award success

HSJ Partnership awards (2024): Bronze winner – Best legal services partnership with the NHS

Health Investor awards (2024): Finalist – Public Sector Legal advisors of the year

Health Investor awards (2023): Finalist – Transactional Legal advisors of the year

## What our clients say

"The Weightmans health team are exceptionally good."
NHS Client
Legal 500, 2024

"They're always wanting to go the extra mile and find ways in which to support."
NHS Client
Chambers and Partners, 2024

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# Deprivation of Liberty

- Autonomy v paternalism
- Best interests decisions where P cannot decide
- But proportionality – the more intrusive, the greater the need for safeguards.  MCA s5, s6.
- Article 5 – where someone is DoL, there needs to be a due legal process, and a right to challenge.
- DoL = (1) **Continuous supervision and control AND not free to leave** + (2) lack of consent + (3) imputable to the state [until 2 June 2026]
- MCA is our framework for making the best interests decisions that may bring restrictions
- DoL/S is our legal framework for the ***scrutiny of the restrictions***

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# So …

- Get the MCA right first and foremost
- DoL/S is the spotlight not a padlock
- Err on the side of caution - Trigger is that P is “at risk of” being DoL
- Impact of Cheshire West – “a gilded cage is still a cage”

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# AGNI – UKSC, 2 June 2026

- Application by Attorney General of Northern Ireland to ask UKSC whether the proposed Code of Practice for DoLS (in N Ireland) is ok, given it would not be compatible with Cheshire West
- Wanted to include idea of “incapacitous consent” – that there can be “valid consent” (so not a DoL) if someone is “happy” with the situation, even though they lack capacity for the decisions about their care.

- DHSC joined in to argue that Cheshire West went too far.

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# AGNI: Cheshire West was wrong

- The “acid test” is too crude a test of objective confinement.
- It needs to be muti-factorial (the “Guzzardi basket”)
- The things Cheshire West discounted ARE in fact relevant –
- Purpose, context, relative normality, objection etc
- Coercion is a “necessary element”
- Objection is key, and medication that suppresses objection is a red flag
- Liberty means physical liberty

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# Domestic setting

Possible, but –

- “The parties identified no decision of the European Court to date which has held that an individual living in their own home is deprived of liberty”.
- “…the restrictions imposed would need to be more severe or extensive to amount to such a deprivation, such as, for example, a combination of restraint, medication, and seclusion.” (para 193).

- Supported living?

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# “Incapacitous consent”

- For the purposes of Article 5 ECHR, it is possible for someone to give “valid consent” to restrictions – and so stop it being a DoL – even though they lack capacity to make the decisions about care and residence under the MCA.

- They just need to have a “sufficient awareness” of their situation to be able to show “whether they are happy or unhappy” with it.

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- They just need to have a “sufficient awareness” of their situation to be able to show “whether they are happy or unhappy” with it.

- **If you’re “happy”, and we know it, there’s no DoL.**

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# “Incapacitous consent”

- MUCH better to focus on the question of objective DoL / confinement, than on subjective “incapacitous consent”.
- If there is no objection / coercion, there is unlikely now to be an objective DoL, so the “consent” is academic.
- Objection / coercion are likely to be clearer ideas than being “happy”, and this avoids the (unnecessary) confusion of the idea of “incapacitous consent” bleeding out of Article 5 into other areas of decisions about treatment.

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# DHSC guidance – 15 June 2026

The multi-factorial assessment includes:

- The type of restrictions (eg locked doors, physical control, supervision, sedation meds, social isolation etc)
- Duration of those restrictions
- The effect of the restrictions on the person
- The manner of implementation of the restrictions
- Objection
- How far from the paradigm prisoner in a cell
- The relative normality (eg greater restrictions would be needed for there to be a DoL at home)

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# DHSC guidance

- For there to be a DoL there must be an element of restriction being imposed on a person against their will.
- Any objection would point towards a deprivation of liberty.
- Compliance does not mean the person is consenting
- Unlikely then to be a DoL if the P's liberty is constrained by heir own illness, condition or impairment – eg if physical disabilities prevent them from leaving and "they are unable to form any desire to leave".

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# DHSC guidance

- Where the person is objecting, then it follows that valid consent is unlikely to be present.
- Objection could include:
- Attempts to leave the setting
- Refusing care or treatment (eg pushing staff away)
- Physical restraint or 1:1 care to manage behaviour
- Covert medication if objecting to medication
- Sedating medication to manage behaviour if it affects an individual's ability to object.

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DCC-i 7 Minute Briefing - Deprivation of Liberty after UKSC/2025/0042

# So – ten points

1. Focus on getting the MCA right.
2. Treat “incapacitous consent” with great caution.
3. Err on the side of caution for DoLS referrals / COP applications – it remains the provider’s responsibility to decide what to refer
4. Acknowledge uncertainty
5. Mitigate this – audit, benchmarking and sharing best practice.
6. The care and restrictions do not change, just because they are no longer regarded as amounting to a DoL (and still need to be enforced).

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# So – ten points

7. This needs careful communication with patients and families.
8. Training for professionals also needs care – to include review of policies / audit of impact on MCA, DOL and consent.
9. Where someone is no longer actually DoL, an ongoing existing DoLS authorisation does not create any liability (the authorisation is the scrutiny, it doesn't create the restrictions)
10. Other safeguards are relevant, even if Article 5 DoL doesn't apply – eg Care Act, MCA, safeguarding and Article 8 (right to private and family life)

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# What next?

- Some more guidance from DHSC, ADASS and CQC
- Code of Practice update likely in 12-18/12
- Case law in the meantime will be inconsistent

- Liberty Protection Safeguards seem unlikely
- COPDOL11 process unlikely to continue

- More work, not less?!

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# Resources

- CQC response – 8 June 2026
- DHSC initial guidance – 15 June 2026
- ADASS response – 5 June 2026, and update – 18 June 2026

- Weightmans' webinar and article

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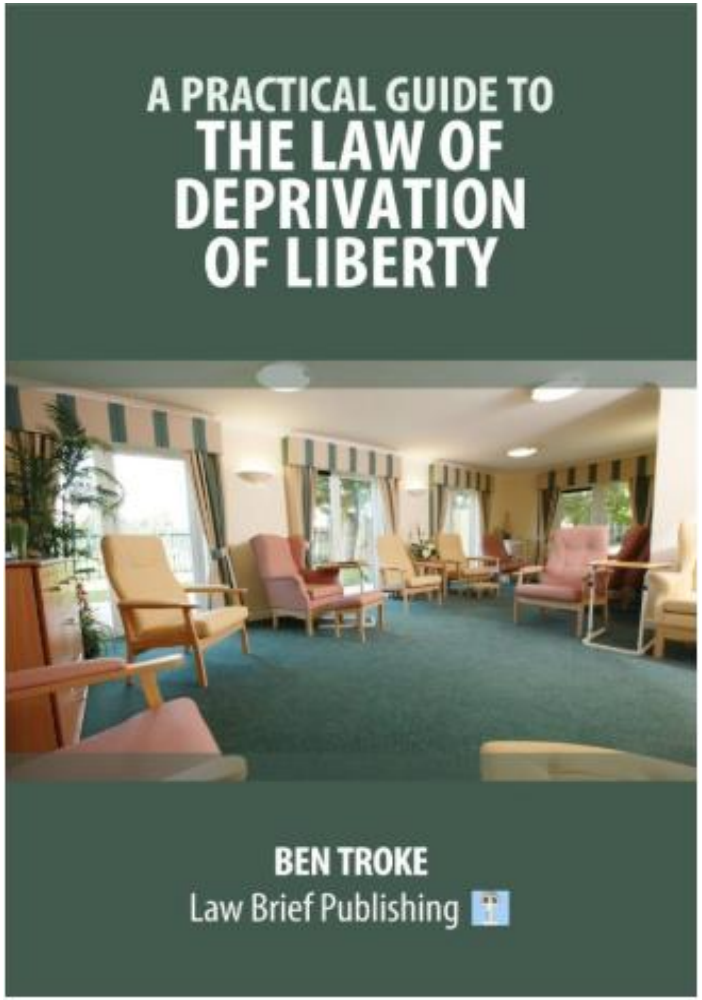


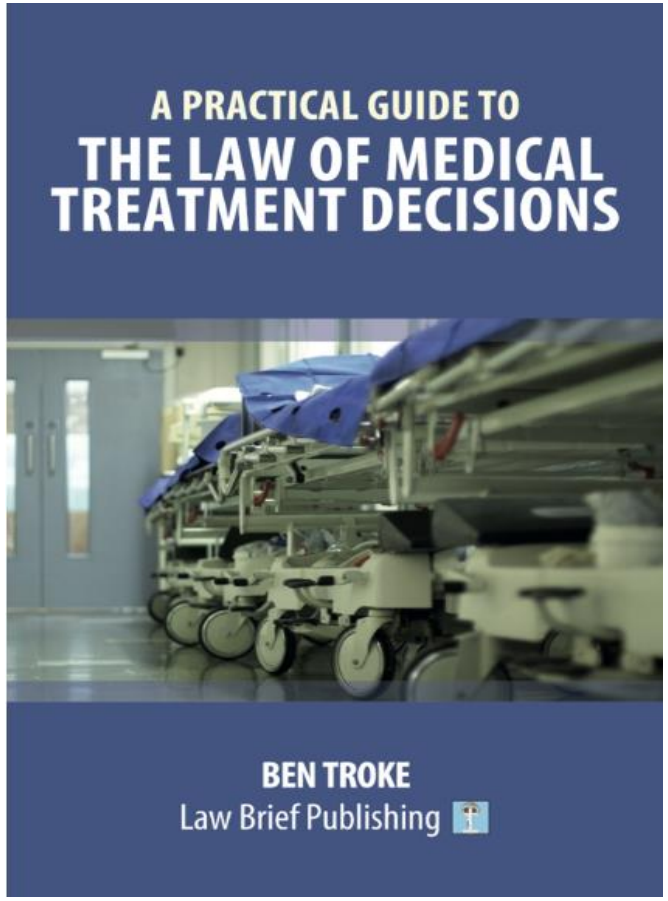


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