

**The Capacity (Advance Decisions  
to Refuse Treatment, etc.) Regulations, 2025**

<i>Made</i>	<i>6<sup>th</sup> May, 2025</i>
<i>Coming into operation</i>	<i>8<sup>th</sup> May, 2025</i>
<i>Laid before the States</i>	<i>, 2025</i>

**THE COMMITTEE FOR HEALTH AND SOCIAL CARE**, in exercise of the powers conferred on it by sections 36, 40 and 57 of the Capacity (Bailiwick of Guernsey) Law, 2020<sup>a</sup> and all other powers enabling it in that behalf, hereby makes the following Regulations:-

**Prescribed forms.**

1. In the Schedule to the Capacity (Bailiwick of Guernsey) Law, 2020 ("**the Law**") -

(a) the following forms are the prescribed forms for the purposes of an advance decision to refuse treatment ("**advance decision**") established under Part 5 of the Law

(i) form ADRT1 is the prescribed form for the

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<sup>a</sup> Ordinance approved by the States of Deliberation on the 30<sup>th</sup> March, 2022.

purposes of section 36(2) in order to make an advance decision,

(ii) form ADRT2 is the prescribed form for the purposes of section 36(3) in order to amend an advance decision, and

(iii) form ADRT3 is the prescribed form for the purposes of section 36(3) in order to revoke an advance decision, and

(b) the following forms are the prescribed forms for the purposes of an advanced care plan established under Part 6 of the Law -

(i) form ACP1 is the prescribed form for the purposes of section 40(2) in order to make an advanced care plan,

(ii) form ACP2 is the prescribed form for the purposes of section 40(3) in order to amend an advanced care plan, and

(iii) form ACP3 is the prescribed form for the purposes of section 40(3) in order to revoke an advanced care plan.

**Prescribed persons for the purposes of life-sustaining treatment.**

2. The following persons are prescribed for the purposes of section 38(4)(b) of the Capacity (Bailiwick of Guernsey) Law, 2020 ("**the Law**") -

- (a) a medical practitioner, who satisfies the conditions of section 1(1)(a) and (b) of the Regulation of Health Professionals (Medical Practitioners) (Guernsey and Alderney) Ordinance, 2015, and
- (b) any other person approved by the Committee, either generally or in a specific case, where the Committee considers that the person has the expertise and experience necessary to carry out the function of a prescribed person.

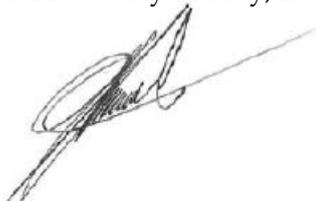
**Amendment of Prescribed Person (Amendment) Regulations.**

3. In regulation 1 of the Capacity (Prescribed Persons) (Amendment) Regulations, 2025 for "2025", substitute "2024".

**Citation, extent and commencement.**

- 4. (1) These Regulations -
  - (a) may be cited as the Capacity (Advanced Decisions to Refuse Treatment, etc.) Regulations, 2025, and
  - (b) shall have effect throughout the Bailiwick.
- (2) These Regulations shall come into force -
  - (a) in Guernsey, Alderney Herm and Jethou, on the 8<sup>th</sup> May, 2025, and
  - (b) in Sark, on the coming into force in Sark of Parts 5 and 6 of the Law.

Dated this 6<sup>th</sup> day of May, 2025

A handwritten signature in black ink, appearing to read 'A. H. BROUARD', with a long horizontal stroke extending to the right.

A. H. BROUARD

President of the Committee for Health & Social Care

For and on behalf of the Committee

SCHEDULE

Regulation 1

Form ADRT1

## **ADVANCE DECISION TO REFUSE TREATMENT**

This Advance Decision to Refuse Treatment ("advance decision") sets out the specified medical treatment which I wish to refuse, if I lack capacity to make that decision when required in the future.

You must fill out all of this form (except the Reasons set out on page 2).

### **PART 1: MY DETAILS**

Name
_____
Address
_____
_____
Date of birth
_____
_____
Any distinguishing features
_____
_____

### **GP details\***

Name
_____
Address
_____
_____
Phone number
_____
_____

## **PART 2: MY ADVANCE DECISION**

**The treatment that I wish to refuse if I lose capacity to make my own decision in future is as follows:**

Details of the treatment I refuse  
Please include as much detail as possible.

### **For the avoidance of doubt:**

#### **Pain relief**

I wish to be given all medical treatment intended to alleviate pain or distress or aimed at ensuring my comfort.

YES      NO      (please delete as appropriate)

### **Reasons (Optional: you do not have to fill in this section)**

This statement explains why I am making this advance decision and what is important to me regarding my health, care and quality of life.

**I have discussed this advance decision with the following:**

Unless this advance decision relates to life-sustaining treatment, it is not necessary to discuss it with anyone. However, it would be advisable to do so.

1. Name

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Address

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Relationship

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Phone

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Email

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2. Name

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Address

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Relationship

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Phone

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Email

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Please go to the next page to answer questions in relation to a Lasting Power of Attorney for health and welfare

**Lasting Power of Attorney for health and welfare**

I have made a Lasting Power of Attorney for health and welfare

YES NO (please delete as appropriate)

Date LPA registered: / /

Name of attorney 1

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Address of attorney 1

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Phone number

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Email

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Name of attorney 2 (if relevant)

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Address of attorney 2

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Phone number

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Email

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Please go to the next page to answer questions in relation to life-sustaining treatment

### **PART 3: LIFE-SUSTAINING TREATMENT**

*This section must be completed if you are refusing life-sustaining treatment. "Life-sustaining treatment" is treatment which in the view of a person providing health care to the person making the advance decision is necessary to sustain life.*

#### **Life-sustaining treatment**

##### **PART A: to be completed by a medical professional (e.g. GP or doctor)**

Medical professional (name)

Address

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Phone

Email

I confirm that I am a prescribed person for the purposes of section 38(4) of the Capacity (Bailiwick of Guernsey) Law, 2020.

I confirm that I have discussed this advance decision with \_\_\_\_\_ \* and given appropriate advice about the specified treatment, the consequences of their decision and any other possible treatment options available.

Signed

Date

\* Insert name of person who is making the advance decision

##### **PART B: Confirmation statement (to be completed by the person making the advance decision)**

I confirm that, where my advance decision relates to life-sustaining treatment, this applies even if my life is at risk.

Signed

Date

## PART 4: CONFIRMATION

To be completed by the person making the advance decision:

I confirm that I am 16 or over, have capacity to make my advance decision and that I have not been placed under any undue pressure to make it.

I confirm that, in making this advance decision, it should be used in the event that I lose capacity to make my own decision regarding the specified medical treatment.

I acknowledge that, where the advance decision relates in full or in part to life-sustaining treatment, my signature must be witnessed in order for the advance decision to be valid.

Signed
Date

To be completed where the advance decision relates in full or in part to life-sustaining treatment:

Witnessed by:
Name
Address
Signed
Date

## **PART 5: REVIEW**

It is advisable, although not essential, to review your advance decision at least every 5 years.

I have reviewed my advance decision and confirm that this reflects my current wishes.

Signed

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Date

Capacity (Bailiwick of Guernsey) Law, 2020, Part 5

**ADVANCE DECISION TO REFUSE TREATMENT**  
**(AMENDMENT)**

This form amends my Advance Decision to Refuse Treatment dated:

/ / .

An Advance Decision to Refuse Treatment ("advance decision") sets out the specified medical treatment which I wish to refuse, if I lack capacity to make that decision when required in the future.

You must complete all of this form, including Parts 1 and 4. You should clearly mark any Parts which you do not want to amend with "No amendment".

**PART 1: MY DETAILS**

Name
_____
Address
_____
Date of birth
_____
_____
Any distinguishing features
_____

## GP details

Name
Address
Phone number

Please go to the next page to answer questions in relation to your advanced decision.

## **PART 2: MY ADVANCE DECISION**

**The treatment that I wish to refuse if I lose capacity to make my own decision in future is as follows:**

Details of the treatment I refuse

Please include as much detail as possible.

### **For the avoidance of doubt:**

#### **Pain relief**

I wish to be given all medical treatment intended to alleviate pain or distress or aimed at ensuring my comfort.

YES

NO

(please delete as appropriate)

### **Reasons (Optional: you do not have to fill in this section)**

This statement explains why I am amending my advance decision and what is important to me regarding my health, care and quality of life.

**I have discussed this amendment to my advance decision with the following:**

Unless this amendment to your advance decision relates to life-sustaining treatment, it is not necessary to discuss it with anyone. However, it would be advisable to do so.

1. Name

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Address

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Relationship

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Phone

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Email

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2. Name

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Address

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Relationship

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Phone

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Email

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Please go to the next page to answer questions in relation to a Lasting Power of Attorney for health and welfare

## **Lasting Power of Attorney for health and welfare**

I have made a Lasting Power of Attorney for health and welfare

YES NO (please delete as appropriate)

Date LPA registered: / /

Name of attorney 1

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Address of attorney 1

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Phone number

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Email

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Name of attorney 2 (if relevant)

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Address of attorney 2

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Phone number

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Email

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Please go to the next page to answer questions in relation to life-sustaining treatment

### **PART 3: LIFE-SUSTAINING TREATMENT**

*This section must be completed if you are refusing life-sustaining treatment. "Life-sustaining treatment" is treatment which in the view of a person providing health care to the person making the advance decision is necessary to sustain life.*

#### **Life-sustaining treatment**

##### **PART A: to be completed by a medical professional (e.g. GP or doctor)**

Medical professional (name)

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Address

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Phone

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Email

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I confirm that I am a prescribed person for the purposes of section 38(4) of the Capacity (Bailiwick of Guernsey) Law, 2020.

I confirm that I have discussed this advance decision with \_\_\_\_\_ \* and given appropriate advice about the specified treatment, the consequences of their decision and any other possible treatment options available.

Signed

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Date

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\* Insert name of person who is making the advance decision

##### **PART B: Confirmation statement (to be completed by the person making the advance decision)**

I confirm that, where my advance decision relates to life-sustaining treatment, this applies even if my life is at risk.

Signed

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Date

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## PART 4: CONFIRMATION

To be completed by the person amending the advance decision:

I confirm that I am 16 or over, have capacity to amend my advance decision and that I have not been placed under any pressure to do so.

I confirm that, in amending the advance decision identified on page 1, the advance decision (as amended) should be used in the event that I lose capacity to make my own decision regarding the specified medical treatment.

I acknowledge that, where the advance decision (as amended) relates in full or in part to life-sustaining treatment, my signature must be witnessed in order for the advance decision to be valid.

Signed
Date

To be completed where the advance decision relates in full or in part to life-sustaining treatment:

Witnessed by:
Name
Address
Signed
Date

Capacity (Bailiwick of Guernsey) Law, 2020, Part 5

**ADVANCE DECISION TO REFUSE TREATMENT**  
**(REVOCATION)**

This form revokes my Advance Decision to Refuse Treatment dated:  
/ / , along with any amendments made to it.

An Advance Decision to Refuse Treatment ("advance decision") sets out the specified medical treatment which a person wishes to refuse, if they lack capacity to make that decision when required in the future.

Where an advance decision is revoked, a medical professional is not required to follow it any more when deciding whether a specified medical treatment can be given.

You must complete Parts 1 and 3 of this form; you may complete Part 2 if you wish.

**PART 1: MY DETAILS**

Name
_____
Address
_____
_____
Date of birth
_____
_____
Any distinguishing features
_____
_____

## GP details

Name
Address
Phone number

## PART 2: REASONS FOR REVOCATION

### Reasons (Optional: you do not have to fill in this section)

This statement explains why I have decided to revoke my advance decision and what is important to me regarding my health, care and quality of life.

## PART 3: CONFIRMATION

To be completed by the person revoking the advance decision:

I confirm that I am 16 or over, have capacity to revoke my advance decision and that I have not been placed under any pressure to do so.

I confirm that I wish to revoke the advance decision identified on page 1 and acknowledge that it should not be used in the event that I lose capacity to make my own decision regarding the specified medical treatment.

Signed
Date

Capacity (Bailiwick of Guernsey) Law, 2020, Part 6

**ADVANCED CARE PLAN**

**PART 1: MY DETAILS**

My full name	
My date of birth	
My address	
Email:	
<b>General Practitioner details</b> Name:	
Address:	
Phone number:	
<b>Social worker (if relevant)</b> Name:	
Address:	
Email:	
Phone number:	

Please go to the next page to answer questions in relation to Lasting Powers of Attorney

**Lasting Power of Attorney**

Please complete the following boxes to state if you have made a Lasting Power of Attorney for Health and Welfare, a Lasting Power for Property and Financial Affairs, or both.

<p><b>Lasting Power of Attorney for Health and Welfare</b></p> <p>I have made a Lasting Power of Attorney for health and welfare</p>	<p>Yes/No (please delete as appropriate)</p> <p>If yes – date registered:</p>
<p>Attorney name:</p> <p>Address:</p> <p>Email:</p> <p>Phone number:</p>	
<p>Attorney name:</p> <p>Address:</p> <p>Email:</p> <p>Phone number:</p>	

Please go to the next page to answer questions in relation to a Lasting Power of Attorney for Property and Financial Affairs

<p><b>Lasting Power of Attorney for Property and Financial Affairs</b></p> <p>I have made a Lasting Power of Attorney for property and financial affairs</p>	<p>Yes/No (please delete as appropriate)</p> <p>If yes – date registered:</p>
<p>Attorney name:</p>	
<p>Address:</p> <p>Email:</p>	
<p>Phone number:</p>	
<p>Attorney name:</p>	
<p>Address:</p> <p>Email:</p>	
<p>Phone number:</p>	

Please go to the next page to state your wishes and preferences for decisions about your care, health and welfare.

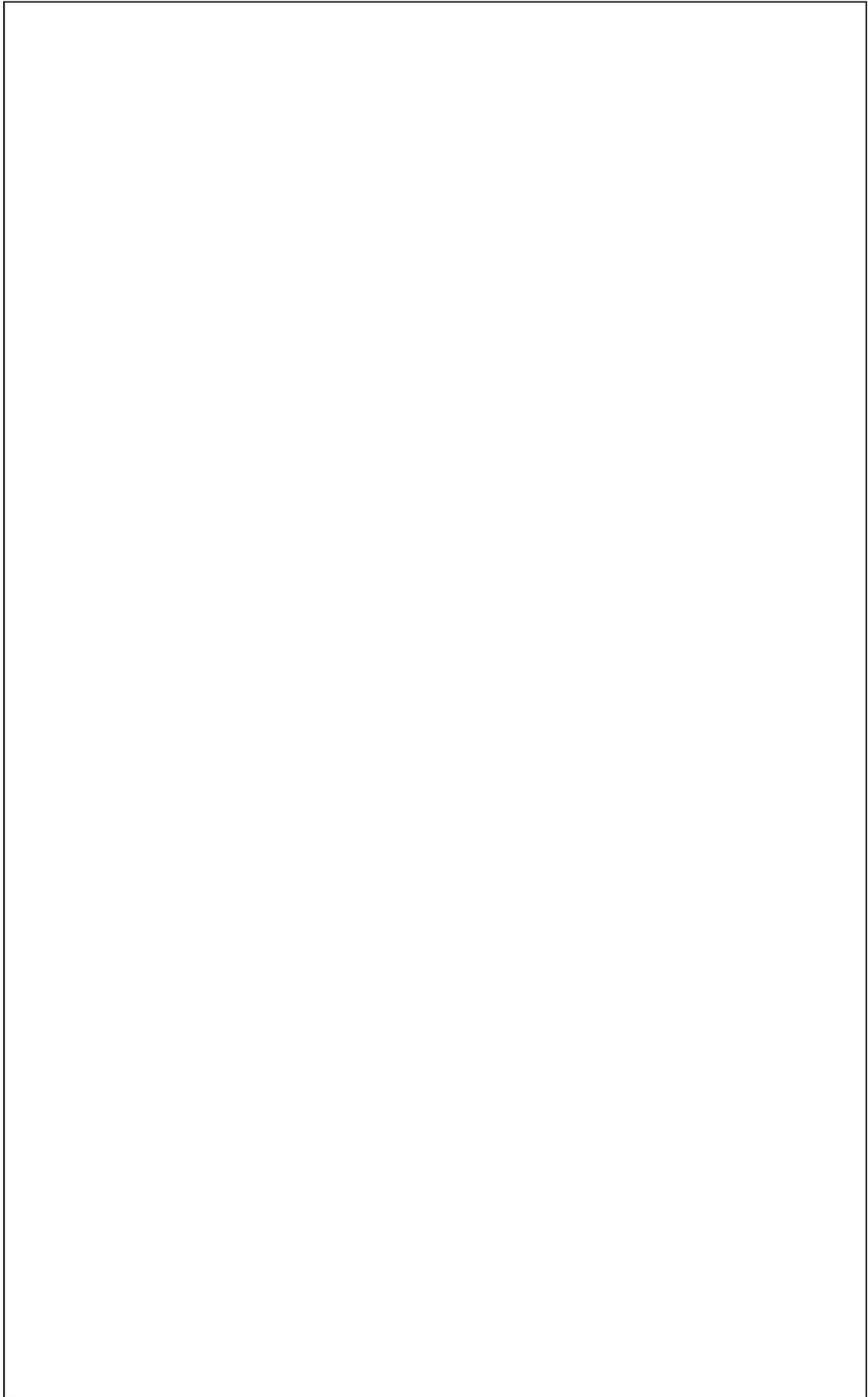
## **PART 2: WISHES AND PREFERENCES**

*Please provide as much information and details about your wishes and preferences so that these can be considered by decision makers or persons carrying out assessments in the future, if you lose capacity to make your own decisions.*

### **Details of my wishes and preferences for decisions about my care, health and welfare.**

*These wishes and preferences might include:*

- *where and how you would like care to be provided to you,*
- *whether you object to care being provided in a way which might restrict your liberty,*
- *who should be consulted in relation to any decisions about your care, and*
- *any religious, spiritual or ethical views which you would want to be respected when care is provided to you.*



**Details of my wishes and preferences for decisions about any end-of-life care and associated arrangements.**

*These wishes and preferences might include the arrangements for your funeral*

Please go to the next page to sign the declaration that this form is your advanced care plan.

### **PART 3: DECLARATION**

I confirm that I am 16 or over, have capacity to make the decisions contained in this advanced care plan and that I have not been placed under any undue pressure to make any of those decisions.

I also confirm that my wishes and preferences contained in this advance care plan should be taken into account by:

- a decision maker person making relevant decisions, and
- any person carrying out an assessment,

when considering my best interests, in the event that I have lost capacity to make my own decision at that time.

Signed
Date

### **PART 4: REVIEW**

It is advisable, although not essential, to review your advanced care plan every 5 years. If it no longer represents your wishes and preferences, you should amend it using Form ACP2 or make a new advanced care plan using Form ACP1.

I have reviewed my advanced care plan and confirm that it reflects my current wishes and preferences. I confirm that I have capacity to review this and have not been put under undue pressure to express the wishes and preferences set out in this advanced care plan.
Signed
Date

**ADVANCED CARE PLAN**  
**(AMENDMENT)**

This form amends my Advanced Care Plan dated:        /        /        .

**PART 1: MY DETAILS**

My full name	
My date of birth	
My address	
Email:	
<b>General Practitioner details</b> Name:	
Address:	
Phone number:	
<b>Social worker (if relevant)</b> Name:	
Address:	
Email:	
Phone number:	

**PART 2: WISHES AND PREFERENCES**

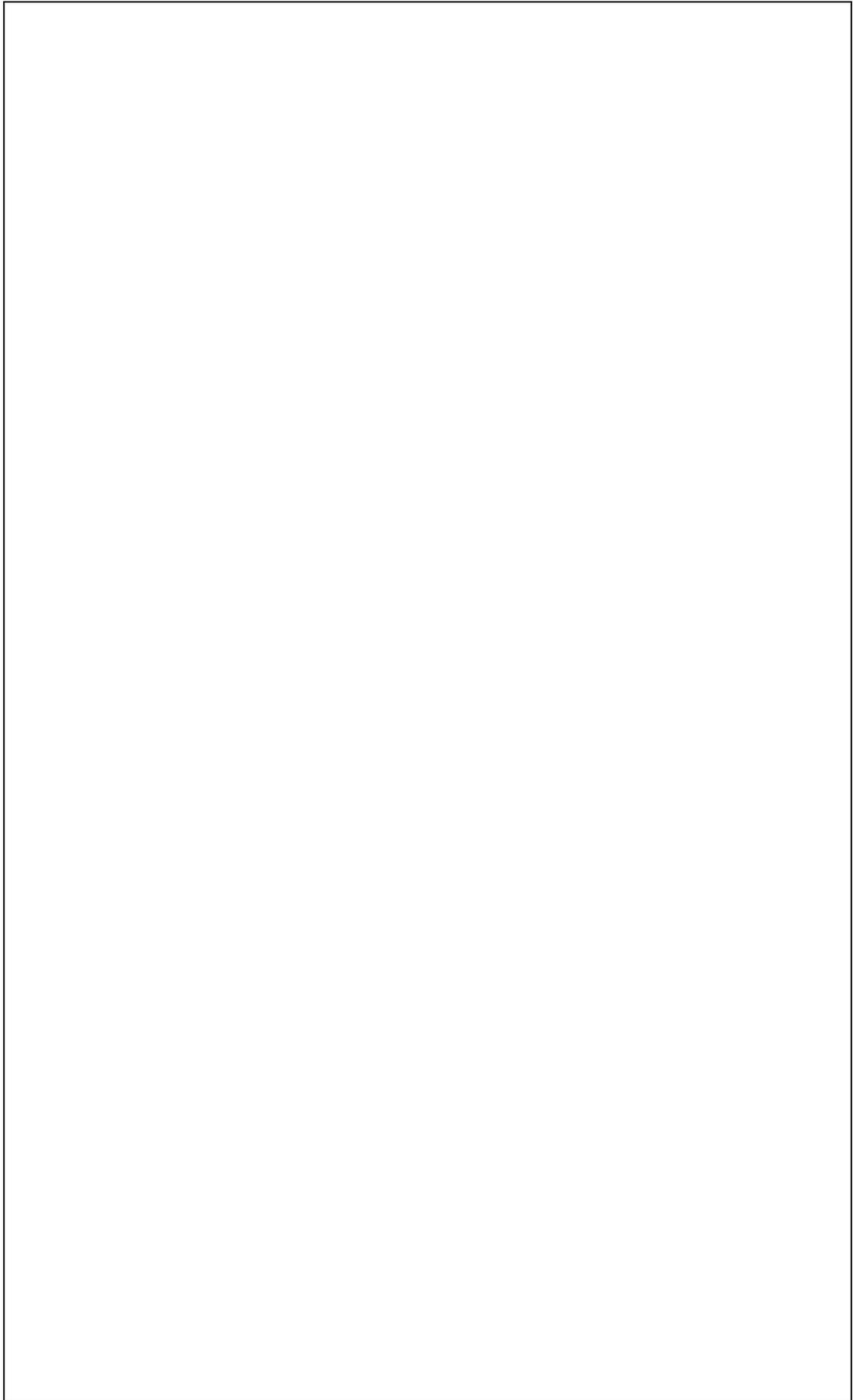
*The wishes and preferences set out below will be substituted for the wishes and preferences set out in your advanced care plan identified on page 1.*

*Please provide as much information and details about your wishes and preferences so that these can be considered by decision makers or people carrying out assessments in the future, if you lose capacity to make your own decisions.*

**Details of my wishes and preferences for decisions about my care, health and welfare.**

*These wishes and preferences might include:*

- *where and how you would like care to be provided to you,*
- *whether you object to care being provided in a way which might restrict your liberty,*
- *who should be consulted in relation to any decisions about your care, and*
- *any religious, spiritual or ethical views which you would want to be respected when care is provided to you.*



**Details of my wishes and preferences for decisions about any end-of-life care and associated arrangements.**

*These wishes and preferences might include the arrangements for your funeral*

Please go to the next page to sign the declaration that this form amends your advanced care plan.

**PART 3: DECLARATION**

I confirm that I am 16 or over, have capacity to make the decisions contained in this advanced care plan and that I have not been placed under any undue pressure to make any of those decisions.

I also confirm that my wishes and preferences contained in this advance care plan should be taken into account by:

- a decision maker person making relevant decisions, and
- any person carrying out an assessment,

when considering my best interests, in the event that I have lost capacity to make my own decision at that time.

I acknowledge that the wishes and preferences set out in Part 2 will be substituted for the wishes and preferences set out in my advanced care plan identified on page 1 and any subsequent amendments.

Signed
Date

**PART 4: REVIEW**

It is advisable to review your advanced care plan every 5 years. If it no longer represents your wishes and preferences, you should make a new advanced care plan.

I have reviewed my advanced care plan and confirm that this reflects my current wishes. I confirm that I have capacity to review this and have not been put under undue pressure to express the wishes and preferences set out in this advanced care plan.
Signed
Date

**ADVANCED CARE PLAN**  
**(REVOCATION)**

This form revokes my Advanced Care Plan dated:        /        /        .

**PART 1: MY DETAILS**

My full name	
My date of birth	
My address	
Email:	
<b>General Practitioner details</b> Name:	
Address:	
Phone number:	
<b>Social worker (if relevant)</b> Name:	
Address:	
Email:	
Phone number:	

## **PART 2: DECLARATION**

I confirm that I am 16 or over, have capacity to revoke the advanced care plan identified on page 1 and that I have not been placed under any undue pressure to revoke this care plan.

I confirm that I wish to revoke that advanced care plan and acknowledge that it is possible that the wishes and preferences contained in that advanced care plan are not taken into account by:

- a decision maker person making relevant decisions, and
- any person carrying out an assessment,

when considering my best interests, in the event that I have lost capacity to make my own decision at that time.

Signed
Date

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### EXPLANATORY NOTE

*(This note is not part of the Regulations)*

These Regulations prescribe forms and persons, for the purpose of Parts 5 (Advance Decisions to Refuse Treatment) and 6 (Advanced Care Plans) of the Capacity (Bailiwick of Guernsey) Law, 2020.

These Regulations also amend a typographical error in the Capacity (Prescribed Persons) (Amendment) Regulations, 2025.

These Regulations come into force on the 8<sup>th</sup> day of May 2025.