Faculty of Forensic & Legal Medicine

Management of Do Not Resuscitate/Do Not Attempt Cardio Pulmonary Resuscitation (DNR/DNAR/DNACPR) decisions in police custody

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Introduction

The public have become more aware of 'Do Not Resuscitate' (DNR) orders (otherwise known as Do Not Attempt Resuscitation – DNAR or Do Not Attempt Cardio-Pulmonary Resuscitation – DNACPR). Cardiac arrest is the final common step in the dying process. In the appropriate context, resuscitation can reverse the dying process, although success rates are low. However, cardiopulmonary resuscitation (CPR) can be a highly invasive medical treatment, which, if applied in the wrong setting, can deprive the patient of dignified death. Do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decisions provide a mechanism to withhold CPR. DNACPR decisions need to be recognised as part of wider conversations about advance care planning and end of life care, and these decisions need to be made in a safe way that protects people's human rights.[1] Approximately 1500 DNACPR incidents are reported annually in the UK. One-third of these report harms, including some instances of death. Problems with communication and variation in trusts' implementation of national guidelines were common. Members of the public were concerned that their wishes, with regard to resuscitation would not be respected. Clinicians felt that DNACPR decisions should be considered within the overall care of individual patients. Some clinicians avoid raising discussions about CPR for fear of conflict or complaint despite evidence suggesting that the majority of patients are not upset by an appropriate discussion surrounding these issues.[2]

There may be concerns that DNACPR decisions may result in a negative impact on overall patient care due to conflation of 'do not resuscitate' with 'do not provide active treatment'.[3] However, this can be overcome by exploring and explaining clearly what the decision means and working out an appropriate care plan with the patient.

It may be helpful to discuss DNACPR decisions in terms of allowing natural death rather than withholding resuscitation.

In view of the specific pressures placed on detainees in police custody, **the FFLM does not support new DNACPR decisions being made in this setting.**

Advance Decisions

Advance decisions (sometimes called a living will) documents a decision made to refuse a specific type of treatment at a future date. To be valid to refuse life-sustaining treatment, it must be written down and signed by both the patient and a witness.

To be legally binding, (in addition to a number of other factors) it must clearly specify the treatments refused and the circumstances in which the patient wishes to refuse them. It is unlikely that many patients will have made their advance directive specifically applicable to the situation of being in police custody and under investigation. Bearing this in mind it is unlikely that many advance directives will be legally binding in the custody setting.

Further information can be found at *https://www.nhs.uk/conditions/end-of-life-care*.[4]

ReSPECT

ReSPECT is the **Re**commended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment. This process should create personalised recommendations for clinical care when a patient loses capacity to make or express specific choices in the future. Its use is increasing and there are a range of useful *resources* available on the RC(UK) website.[5]

Patients in police custody

Patients (detainees/detained persons) in police custody have the same range of medical conditions as those not in police custody.[6,7] The standard of healthcare they receive should be the same as that which they would receive in the community. Cardiac conditions and chronic illnesses may be seen frequently. Acute conditions such as alcohol or drug intoxication, mental health conditions and unwillingness to cooperate with police may sometimes result in lack of, or incorrect information, which does not allow a full assessment of medical status or the true wishes of the individual.

It would be unusual for a detainee known to be at imminent risk of cardiac arrest to remain detained in police custody. However, there may be occasions when an individual (for example with known cardiac disease) develops chest pain, angina or is otherwise at risk of cardiac arrest. There may also be patients with terminal conditions (for example advanced metastatic carcinoma). However, even in the non-detention setting it can be difficult to establish the patient's wishes or to get relevant information about their underlying condition to make a considered judgement at the time they suffer a cardiac or respiratory arrest and an urgent decision has to be made.

So, if a patient has an existing condition which makes cardiac or respiratory arrest likely, establishing a management plan, in advance, will help to ensure the patient's wishes and preferences about treatment can be taken into account. Further, if appropriate, a DNACPR decision is made and recorded.[8] Should a patient be considered to be likely to have cardiac or respiratory arrest it is very unlikely they should remain in police custody. Occasionally, however, a patient may well be fit to detain and interview if medically stable and any pre-existing DNACPR decisions should be established and confirmed at the clinical assessment.

In particular, meticulous medical records must be kept of all communications, and their outcome with the following, (with the consent of the patient):

1. Patient
2. Custody Officer
3. Other medical staff, (e.g. GP/hospital consultant)
4. Investigating Officers
5. Family or partner

It will be essential the clinician assessing fitness for detention in custody has a full awareness of the police process and timelines, and communicates the status of the patient, the findings and the intended management and the presence of a DNACPR decision, to clinicians responsible for care, whilst the patient is detained in custody.

For the majority of patients seen, in the absence of verifiable, documented DNACPR decision, if a patient collapses in custody, CPR should be initiated. It will be an exceedingly rare occasion when, even taking into account the information above, a healthcare professional will have a detailed history of the detainee and therefore resuscitation is likely to be attempted in an emergency situation.

The General Medical Council clearly states that CPR should be attempted 'unless doctors are certain they have enough information about patients' wishes or that the outcome will be unsuccessful.'[8]

A DNA/DNAR or CPR decision should not override clinical judgment when cardiac or respiratory arrest occurs due to a reversible cause, which was not previously anticipated, for example when a patient chokes on food. In all cases, it is essential that the clinician records contemporaneously in detail the reasons for their decision at the time, and their management plan based on those reasons.

Further advice

More detailed advice for clinicians on when to attempt to resuscitate, and when it is appropriate not to do so, is available from specialist bodies, for example:

Cardiopulmonary resuscitation – standards for clinical practice and training – a joint statement from the Royal College of Anaesthetists, the Royal College of Physicians of London, the Intensive Care Society and the Resuscitation Council (UK)

Decisions relating to cardiopulmonary resuscitation - a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016)

Integrated policy on Do Not Attempt Cardio-pulmonary Resuscitation (2010) NHS Scotland. The 5th Edition of Immediate Life Support considers 'Making decisions about CPR' in some detail

'Sharing and Involving - a clinical policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for adults in Wales' (April 2022)

Talk CPR Although primarily focussed on decisions in Wales there are a range of resources and videos exploring relevant issues.

Additionally:

- advice on specific cases may be sought from the healthcare professional's medical defence organisation.
- a death in custody will need to be reported to: HM Coroner, The Independent Office of Police Conduct (England & Wales)/ Procurator Fiscal (and should also be reported to the Police Investigations and Review Commission) (Scotland)/The Police Ombudsman for Northern Ireland.

References

1. Care Quality Commission
Protect, respect, connect - decisions about living and dying well during COVID-19
2021

2. Gorton AJ, Jayanthi NV, Lepping P, Scriven MW
Patients' attitudes towards 'do not attempt resuscitation' status
J Med Ethics. 2008 Aug;34(8):624-6

3. Perkins GD, Griffiths F, Slowther A-M
Do-not-attempt-cardiopulmonary-resuscitation decisions: an evidence synthesis
Health Services & Delivery Research 2016 4 11 April 2016

4. NHS
Advance decision to refuse treatment (living will)

5. Resuscitation Council (UK)
Resuscitation Council UK introduces version 3 of ReSPECT plan

6. Payne-James JJ, Green PG, Green N et al
Healthcare issues of detainees in police custody in London, UK
J Forensic Leg Med. 2010 Jan;17(1):11-7

7. Rekrut-Lapa T, Lapa A
Health needs of detainees in police custody in England and Wales
Literature review. J Forensic Leg Med 2014 Oct; 27 69-75

8. General Medical Council
Cardiopulmonary resuscitation (CPR)

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Send any feedback and comments to forensic.medicine@fflm.ac.uk

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