



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

Dec 2018 Review date Dec 2021 – check [www.fflm.ac.uk](http://www.fflm.ac.uk) for latest update

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## Introduction

There is an increasing awareness within the general population 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 right context, resuscitation can reverse the dying process, yet success rates are low. However, cardiopulmonary resuscitation (CPR) is 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. Recent scientific and lay press reports suggest that the implementation of DNACPR decisions in NHS practice is problematic. 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.<sup>i</sup>

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'<sup>ii</sup>. 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 do not advocate 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 [www.nhs.uk/conditions/end-of-life-care/](http://www.nhs.uk/conditions/end-of-life-care/)

## Patients in police custody

Patients (detainees/detained persons) in police custody have the same range of medical conditions as those not in police custody<sup>iii iv</sup>. 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 that makes cardiac or respiratory arrest likely, establishing a management plan, in advance, will help to ensure that the patient's wishes and preferences about treatment can be taken into account and that, if appropriate, a DNACPR decision is made and recorded<sup>v</sup>. Should a patient be considered to be likely to have cardiac or respiratory arrest it is very unlikely that 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 communication and outcome of that communication 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 that the healthcare professional 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 subsequent healthcare professionals 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 a 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'.<sup>iv</sup>** A DNA/DNAR or CPR decision should not override clinical judgment when cardiac or respiratory arrest occurs due to a reversible cause that was not previously anticipated as part of the disease process, for example when a patient chokes on food. In all cases it is essential that the healthcare professional records contemporaneously in detail the reasons for their decision-making 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 (October 2007)*

*Integrated policy on Do Not Attempt Cardio-pulmonary Resuscitation (2010) NHS Scotland. The 4th Edition of Immediate Life Support considers 'Making decisions about CPR' in some detail.<sup>vi</sup>*

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: 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

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- iii Payne-James JJ, Green PG, Green N et al  
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J Forensic Leg Med. 2010 Jan;17(1):11-7
- iv 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
- v General Medical Council  
*Cardiopulmonary resuscitation*
- vi Resuscitation Council (UK)  
*Immediate Life Support (4th Edition)*  
January 2016

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