SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2025] FAI 12

EDI-B784-24

DETERMINATION

BY

SHERIFF JULIUS KOMOROWSKI

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

STEPHEN CHARTERS

EDINBURGH, 12 February 2025

1. The sheriff, having considered the information presented at an inquiry into the death in legal custody of Stephen Charters (Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, section 2(4)), determines as follows.

Section 26(2)(a)

2. On 19 June 2022, Stephen Charters died at HM Prison Edinburgh, 33 Stenhouse Road, in Hermiston Hall, Level 3, North, in a communal area. He collapsed suddenly at around 9.30am and his death was confirmed at 2.40pm.

Section 26(2)(b), (c), (d)

3. His death did not occur from an accident. His death was from natural causes. His death was caused by coronary artery atheroma resulting in ischaemic heart disease. He had a history of breathlessness and chest pains, consistent with angina.

Section 26(2)(g)

4. In accordance with his wishes, on 1 May 2020, a "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) order was put in place. A nurse attended to him very shortly after his collapse on 19 June 2022, and immediately provided medical assistance, but stopped shortly after upon being informed of the DNACPR order.

5. The DNACPR order was put in place following an initial request by the deceased on 2 March 2020 discussed with clinical staff, letters handwritten by him of 19 March and 2 April 2020, correspondence received from his solicitors to the same effect, and finally a discussion with a general practitioner on 1 May 2020.

6. The electronic system for medical records operated for patients in HM Prison Edinburgh has a prompt any time the records are viewed informing the viewer of the DNACPR order. The deceased was seen by clinicians in 2021 on 19 February, 9 and 15 April, 7 and 11 June, and 23 August; he was seen in 2022 on 5 January, 28 April, 17 May, 31 May and 14 June. It is likely that a clinician would have been made aware of the DNACPR order on each of those occasions.

Section 26(2)(e), (f)

7. There was no defect in any system of working which contributed to the death, nor are there any precautions that could have been reasonably taken that realistically might have prevented the death.

Section 26(1)(b)

8. No recommendations are appropriate as to the taking of reasonable precautions, as to a system of working, or the taking of any other steps, as might realistically prevent other deaths on other circumstances.

NOTE

[1] This determination follows preliminary hearings on 7 August and 23 September 2024, and a full hearing on 14 October 2024. The procurator fiscal, as investigator of deaths, as well as the Scottish Ministers (responsible for HMP Edinburgh) and Lothian Health Board (responsible for the medical care of prisoners in HMP Edinburgh) were represented. The next of kin had informed the procurator fiscal that they did not wish to participate in the inquiry proceedings.

[2] I received a joint minute setting out the circumstances of the death itself, including an agreed narration of events apparent from Closed Circuit Television (CCTV) recording of the collapse and death of Stephen Charters. The joint minute agreed the provenance of the CCTV recording as well as certain documents and statements from

witnesses. The procurator fiscal, the Ministers and the Health Board provided written submissions.

[3] The written materials lodged included some policy or guidance documents from the Scottish Prison Service and the National Health Service regarding DNACPR orders, as well as a statement from Doctor Barbara Mundweil, General Practitioner at HMP Edinburgh, following my request at a preliminary hearing for material on this subject.

[4] The collapse and death of the deceased was well attested from the CCTV recording as well as the written accounts of the nurse and one of the prison officers who attended upon him shortly after his collapse. There is nothing suspicious as to his demise. Because of the CCTV recording a precise account of events can be given.

The immediate circumstances of the death

[5] At the time the deceased was on cleaning duties. He suddenly collapsed whereupon others quickly attended to him. Within 13 seconds another prisoner had went to him and placed him in the recovery position. Within 35 seconds of his collapse, three prison officers had attended to him. A minute and 31 seconds after his collapse, a nurse on hand. About 3 to 5 minutes after his collapse, written confirmation of the DNACPR order was obtained, read, and acted on so that medical treatment ceased.

[6] The cause of death I have set out reflects that recorded in the death certificate by the forensic pathologist who performed a post-mortem, which in turn reflects her report. The pathologist noted the deceased's history of heart issues. She noted enlargement of

part of the heart as well as severe narrowing of three of the main coronary arteries with associated extensive scarring of the heart muscles. His condition, the pathologist stated, could have caused sudden death at any time. There was no evidence of bodily injury or intoxication.

Medical care for the condition leading to death

[7] The deceased appeared to have fairly frequent access to medical staff. The records of his treatment are redolent of his condition being conscientiously reviewed and adjusted. As I have noted above, the deceased was seen by clinicians for various purposes in 2021 on 19 February, 9 and 15 April, 7 and 11 June, and 23 August; and in 2022 on 5 January, 28 April, 17 May, 31 May and 14 June. The deceased contracted coronavirus disease (COVID-19) in April 2021 and March 2022. His complaints of breathlessness and the like were thought either to be respiratory (lung) or cardiac (heart) related. On 13 September 2021, he was referred to a Covid Rehabilitation Clinic for assessment. On 18 October 2021, he underwent a Computed Tomography (CT) scan. Various treatments were trialled (salbutamol inhaler, Glyceryl Trinitrate (GTN) spray, bisoprolol and amlodipine).

"Do Not Attempt Cardiopulmonary Resuscitation" orders

[8] Given the passage of time since the DNACPR order was put in place and the eventual death, I thought it right to inquire into the practice and procedure regarding such orders.

DNACPR orders generally

[9] Lothian Health Board provided a statement by Dr Barbera Mundweil. She has been a general practitioner at HM Prison, Edinburgh since August 2022, and for the 12 years before that was a *locum* GP at different prisons and surgeries. Given she was not a salaried GP for HM Prison, Edinburgh at any material time, I understood her evidence to allow me to be informed of general practice rather than particular steps taken for the deceased.

[10] Dr Mundweil explained that DNACPR orders were a "very rare occurrence". She stated that in a prison population of around 850 at Edinburgh, many of whom had chronic health conditions, she thought no more than two or three had DNACPR orders. She explained that patients considering a DNACPR order are advised that, for those whose hearts suddenly stop beating outside of hospital, their chances of surviving that episode to the point of discharge from hospital is usually 5 - 10%. She explained that the electronic system used for medical records at HM Prison, Edinburgh, involves a "pop-up" screen which would alert the user to the DNACPR order, which the clinician would require to "click" on in order to progress to view the records. There is a section in the paper form for a DNACPR order which allows for a review date to be specified but it was not Dr Mundweil's practice to use that. Outside of a hospital setting she considered this "superfluous". There is no record of a review date for the DNACPR order for the deceased.

[11] The "Governor's and Managers ACTION 37A/13: Do Not Attempt Cardiopulmonary Resuscitation Policy (DNACPR)", dated 4 July 2013, provides as follows:

a. The prison policy was to implement Scottish Government policy in a prison setting of preventing:

> "inappropriate, futile and/or unwanted attempts at CPR which may cause significant distress to patients and families as a death with an inappropriate CPR attempt may be undignified and traumatic".

b. Overall responsibility for an advance decision about CPR rested with the senior clinician responsible for the patient which, in the context of prison, would usually be the GP. A decision to put in place a DNACPR order was the responsibility of the National Health Service.

c. An "frequently asked questions" sheet explains that the DNACPR should be reviewed whenever the patient's condition changes, and that a "timeframe for review should be stated on the form when it is first signed", which was the responsibility of the NHS.

[12] An updated policy (Governor's and Managers ACTION 027A/23: Do Not Attempt Cardiopulmonary Resuscitation Policy (DNACPR), dated 11 August 2023), published since the death, contains substantially the same terms to what I have noted from the policy of July 2013. That includes provision for a review date.

[13] The "Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy" of NHS Scotland from August 2016 explains that where cardiopulmonary resuscitation is quite likely to restore a person to a quality of life they would value, or

even where it had only a "poor or uncertain outcome", the patient's wishes were "paramount" (p. 7). I understand such cases with a poor or uncertain outcome to be distinct from cases where CPR would be undoubtedly futile, or where the person concerned was in the very advanced stages of a fatal illness. Only in the latter cases might CPR not be attempted as a matter of clinical judgment independent of the patient's wishes.

[14] The NHS policy explains that a DNACPR order is distinct from general withholding of life-saving or other treatment (p. 7). Thus, for example, treatment in an intensive treatment unit might still be appropriate, as might significant interventions such as blood transfusion or intravenous antibiotics (pp. 7, 10), even though a DNACPR order is in place.

[15] The NHS policy recites studies to the effect that where cardiac arrest occurs out of hospital, survival to hospital discharge is usually 5-10% (p. 12); I presume Dr Mundweil's usual advice to patients regarding survival rates (*infra*) is a reference to this. The policy further notes that rib fractures and hypoxic brain injury might be sustained respectively because of or despite CPR (p. 12).

[16] The NHS policy further states that a "competent advance refusal" by a patient will be one constituted by the "recorded, sustained wishes of the patient who has capacity for that decision" (p. 17). A "competent patient" can make an advance refusal of CPR even where it is "likely" to be medically successful, and no reason has to be given by them (p. 19). The policy states that "review of CPR decisions must be done on

a clinically appropriate and individualised basis", and that a "timeframe for review … should reflect the variability of the patient's clinical situation." (p. 22).

The DNACPR order process for the deceased

[17] On 2 March 2020, the deceased is noted in his medical records requesting that a DNACPR order be put in place, and advising that a letter from his lawyer confirming his wishes was forthcoming.

[18] On 19 March 2020, the deceased put in a handwritten request, referring to prior enquiries, and asking whether the physician had received a letter from his solicitor regarding instructions for "DNR [do not resuscitate]", not to give any kind of medication (including intravenously)", and "nil by mouth".

[19] On 2 April 2020, the deceased put in handwritten request stating that:

> "Taking into consideration the restrictive movements because of [COVID-19] … wondering if I'll get to see the Doctor, I would kindly make it clear of (D.N.R) DO not resuscitate under any circumstances. No medication to be given externally or internally to keep me alive. However in the case of pain I agree to morphine only allowed to be used."

I understand the reference to his doubts as to whether he would get to see a doctor to be for the purposes of confirming his wishes not to receive CPR. That fits with this being the latest of several requests. I do not understand it to be some expression as to the futility of hoping for medical treatment in the event of emergency. It would not make obvious sense to withhold consent for treatment on the basis that treatment in any event was unlikely to be available.

[20] On 30 April 2020, it was noted in the deceased's medical records that correspondence about DNACPR had been received including from his lawyer.

[21] On 1 May 2020, the deceased saw a physician for the purposes of discussing his wishes about medical treatment. It was noted that there was a strong family history of heart problems, that he did not want his life prolonged, with "no medication to be given externally or internally to keep me alive", and a request for morphine only for pain relief. He was told that treatment for the results of self-harm (such as a suicide attempt) would be an exception to his wishes being followed. It was from this point that there was an effective DNACPR order in place.

[22] In this case the refusal of the deceased of CPR was a recorded and sustained wish. There was nothing to indicate that the deceased lacked capacity. I have seen no reference to diagnosed mental illness. There is no indication of attempts at suicide or suicidal ideation. Having regard to the limited rate of CPR success, and the potential deficits even in the event of success, this was a decision that this deceased arrived at quite understandably and reasonably. The limited extent to which DNACPRs are in place for prisoners, in Edinburgh at least, is consistent with them resulting from clinically appropriate decisions and/or genuine, freely expressed exercises of patient autonomy, rather than a manifestation of despairing impulses similar to that which might move someone to suicide or other self-harm.

Broader issues

[23] The wishes of the deceased not to receive life-saving medical treatment extended beyond CPR and encompassed virtually any intervention. Given the cause of his death, whether these broader wishes would or ought to have been observed did not arise. Broader issues regarding withholding treatment generally are outside the scope of this Inquiry.

[24] There appears to have been no review date set for the deceased's DNACPR order, and it is not the practice of the current GP at HMP Edinburgh to enter a review date on such orders. That appears at odds with the Scottish Prison Service and National Health Service guidance. But I cannot conceive that this was of any material consequence for the deceased. His condition did not appear to vary in a material way. His clinicians would have had the DNACPR order automatically brought to their attention on several occasions. He appears to have been treated in an attentive manner and had there been any cause to revisit the DNACPR order, I think that would have been done. Accordingly, I consider it is outside the scope of this Inquiry to make any finding or recommendation as to the appropriate practice of entering a review date for a DNACPR order. I suggest, though, that either the SPS and NHS guidance be followed on fixing a review date or if the clinical consensus is that this is inappropriate for those outside a hospital setting, that revised SPS guidance is issued.

Conclusions

[25] The deceased died in prison from heart disease following long-standing complaints of chest pains. He appears to have been attentively treated for his medical conditions in the years preceding his death. He was immediately attended to on his collapse, treatment only not progressing once a DNACPR order was promptly brought to notice. The DNACPR order reflected the sustained wishes of the deceased and was made following his discussion with a physician. DNACPR orders are not commonplace for that prison. No review date appears to have been set for the order, which seems at odds with the relevant policy, though there is no reason to think this was of any consequence for this deceased.