

OVERVIEW

Following the death of Toby in early 2025, the Isle of Wight NHS Trust conducted a Patient Safety After Action Review. The Isle of Wight Safeguarding Adults Board also reviewed the case under its statutory duty. While it did not meet the threshold for a formal safeguarding review under the Care Act, it was agreed that important learning should be shared, particularly regarding the application and interpretation of DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions.

A DNACPR decision is made to prevent attempts at resuscitation in the event of a cardiac arrest when such intervention would be medically futile, or unlikely to provide meaningful benefit, particularly in patients who are seriously ill, frail, or nearing the end of life.

A reversible cause refers to a sudden, treatable medical emergency, such as choking or anaphylaxis, that can lead to cardiac or respiratory arrest but may be effectively reversed with prompt intervention. In such cases, treatment should still be provided, even if a DNACPR is in place, as the underlying condition is potentially reversible.

SUMMARY OF THE CASE

Toby, aged 81, lived in a supported living home for over 35 years. He was described as a kind and gentle man who enjoyed the outdoors, music, and train videos. Toby lived with multiple health conditions, including a learning disability, autism, asthma, heart disease, and type 2 diabetes.

In January 2025, Toby experienced a heart attack and with support from multiple agencies, he made the considered decision to implement a DNACPR directive.

A few weeks later, Toby collapsed while eating lunch. Staff called 999, believing that he may have choked. The 999-call handler asked staff to begin Cardiopulmonary Resuscitation (CPR), but they declined, citing the DNACPR. When the ambulance crew arrived, Toby was found unresponsive with a clear airway. Sadly, there were no lifesaving opportunities. A post-mortem confirmed the cause of death as choking.

KEY FINDINGS:

- The 999 call was initially triaged as a cardiac arrest. It was not until six minutes into the call that choking was identified as the likely cause.
- Despite choking being a reversible cause, the call handler did not challenge the decision not to commence CPR.
- Paramedics enroute identified the need for CPR due to the reversible cause and relayed this to dispatch, but the message was not passed on to the call handler or staff on scene.
- The standard DNACPR form lacks the opportunity to clarify decisions involving reversible causes.
- Whilst DNACPR guidance was in place at the supported living home, it did not include information on reversible causes, and no formal training was in place for understanding DNACPR decisions.
- There was an expectation that staff would follow the DNACPR form exactly as written, without guidance on exceptions.

WHAT THIS MEANS FOR YOU:

- ☒ **Review** organisational guidance on DNACPR to ensure it covers reversible causes.
- ☒ **Consider** a ReSPECT plan alongside DNACPR decisions, outlining treatment in a future emergency
- ☒ **Challenge** what you do not understand and raise issues with the person completing the DNACPR form
- ☒ **Understand** what constitutes a reversible cause and seek additional training if needed.
- ☒ **Know when to escalate**, even with a DNACPR in place, emergency intervention may still be appropriate.
- ☒ **Ensure** workplace first aid training includes understanding DNACPR's and reversible causes.
- ☒ **Participate in simulations** involving choking and DNACPR scenarios to build confidence and clarity in real-time decision-making.

LINKS FOR BEST PRACTICE AND FURTHER LEARNING

Resuscitation Council UK – [Decisions relating to cardiopulmonary resuscitation](#)

Care Quality Commission - [Protect, respect, connect – decisions about living and dying well during COVID-19](#)

NHS - [Do not attempt cardiopulmonary resuscitation \(DNACPR\) decisions](#)

ReSPECT - [ReSPECT | Resuscitation Council UK](#)