Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Kernaghan, a prisoner at HMP Doncaster, on 11 November 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Daniel Kernaghan died of community acquired pneumonia in hospital on 11 November 2020 while a prisoner at HMP Doncaster. Mr Kernaghan was 82 years old. I offer my condolences to Mr Kernaghan's family and friends.

Mr Kernaghan had several serious long-term health conditions, including vascular dementia, and used a walking frame or walking sticks to get around. During 2020, he became increasing frail and confused and suffered an increasing number of falls.

The clinical reviewer is satisfied that much of the care Mr Kernaghan received in relation to his social care and long-term health conditions was equivalent to that which he could have expected to receive in the community. She also found that the care he received when he was acutely ill was timely and responsive.

However, the clinical reviewer was concerned that the clinical care in relation to Mr Kernaghan's falls risk, advance care planning and end of life care was not equivalent to that which he could have expected to receive in the community.

I share the clinical reviewer's concern that Mr Kernaghan was discharged from hospital and returned to Doncaster in the early hours of 5 October, despite hospital therapists stating that this would not be a safe discharge, and had to be readmitted to hospital again that evening. Treatment in hospital is outside the PPO's remit, but I note that the clinical reviewer considers that the NHS commissioners need to address this with secondary care providers.

I also share the clinical reviewer's concern that the post-mortem examination found that Mr Kernaghan had an undiagnosed hip fracture that had not been identified by healthcare staff.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister, CB
Prisons and Probation Ombudsman **July 2021**

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Summary

Events

1. In 2006, Mr Daniel Kernaghan was sentenced to life imprisonment for murder. After spending time in various prisons, he was transferred to HMP Doncaster in November 2018.

2. Mr Kernaghan had a significant number of long-term health conditions, including epilepsy, vascular dementia, heart disease, type 2 diabetes, high blood pressure, chronic kidney disease, pancytopenia (a low blood cell condition) and deafness. He was frail and used a walking frame or wheelchair to get around.

3. Mr Kernaghan saw healthcare staff frequently and he had daily social care support. Appropriate care plans were created to manage his long-term conditions and he was referred to hospital when his health deteriorated.

4. During 2020, and particularly from October onwards, Mr Kernaghan had a number of falls. On 4 October, he was taken to hospital after falling and complaining of severe hip pain. X-rays showed he had not fractured his hip. He was discharged to Doncaster in the early hours of the following morning, despite hospital therapists stating this would not be a safe discharge. That evening, he was taken back to hospital because he was in pain and his health had deteriorated. A CT scan did not show any injuries and he was discharged to Doncaster again early on the morning of 6 October.

5. On 7 October, he was taken back to hospital where he was diagnosed with sepsis (a life-threatening condition), as a result of a lower respiratory tract infection and was placed on end of life care. However, his condition later improved, and he returned to Doncaster on 21 October.

6. On 30 October, prison healthcare staff sent Mr Kernaghan back to hospital because his vital signs were outside the normal range. Hospital staff discharged him the next day and said that prison healthcare staff should consider an advance care plan as, given his frailty and dementia, recurrent hospital admissions were not in his best interests.

7. On 3 November Mr Kernaghan had an unwitnessed fall. On 6 November, he had another fall and was seen by a prison GP who noted that he had no injuries.

8. Mr Kernaghan's health continued to deteriorate and on 9 November, he was admitted to hospital and diagnosed with pneumonia. He died on 11 November.

9. The post-mortem found that he died of pneumonia. He also had vascular dementia and a hip fracture which contributed to but did not cause his death.

Findings

Clinical care

10. The clinical reviewer concluded that the care Mr Kernaghan received in relation to his social care, transfer planning, reception screening and long-term conditions was equivalent to that which he could have expected to receive in the community.

She also found that the care he received when he was acutely ill was timely and responsive.

11. However, the clinical reviewer was concerned that the clinical care in relation to Mr Kernaghan's falls risk, mobility, advance care planning and end of life care was not equivalent to that which he could have expected to receive in the community.

12. The clinical reviewer was also concerned that Mr Kernaghan was discharged from hospital and returned to Doncaster in the early hours of 5 October 2020 against hospital therapist's advice, and considered that this needs to be taken forward by NHS commissioners and addressed with secondary care providers.

Recommendations

- The Head of Healthcare should review the falls policy and ensure that healthcare staff know the process and procedures for post falls to ensure appropriate timely interventions for those at risk of falling in line with NICE guidance.
- The Head of Healthcare should review the provision of advance life planning and end of life care to ensure appropriate care plans and resources are in place and are delivered in a timely and responsive way, so that all prisoners who are at the end of life are treated with respect and dignity.
- The Head of Healthcare should review dementia care including training for healthcare staff to ensure robust holistic care is provided to prisoners with dementia and allow further appropriate end of life care planning when required.
- The Head of Healthcare should ensure that all staff are trained in the escalation process of elevated NEWS2 scores and are aware of the need for a review and documentation of forward planning to ensure appropriate, timely and responsive care during times of acute deterioration.
- The Head of Healthcare should contact the discharge team at Doncaster Royal Infirmary to raise the issue regarding Mr Kernaghan's discharge from hospital on 4 October 2020, to enable the discharge team to investigate Mr Kernaghan's unsafe discharge back to HMP Doncaster.
- The NHS Commissioners should address with secondary care providers why Mr Kernaghan was discharged back to HMP Doncaster on 5 October 2020, despite hospital therapists advising against this.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her.

14. The investigator obtained copies of relevant extracts from Mr Kernaghan's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Kernaghan's clinical care at the prison.

16. We informed HM Coroner for Yorkshire South East of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The PPO's family liaison officer wrote to Mr Kernaghan's next of kin, his sister, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Doncaster

19. HMP & YOI Doncaster is a local category B and resettlement prison, operated by Serco, which houses a male population of up to 1,145 individuals, including around 200 young offenders aged 18-20.

20. Physical and mental health care services are provided by Care UK.

HM Inspectorate of Prisons (HMIP)

21. The most recent inspection of HMP Doncaster was in September 2019. Inspectors found that health services had improved overall and working relationships with other prison departments were good. A wide range of primary care services was available and waiting lists were generally short. There was age-appropriate emphasis on well-being, and the management of prisoners with long-term conditions was effective. Social care provision was good.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to September 2019, the IMB reported that members had observed commitment to high standards of patient/client care and actions by Care UK managers and clinical staff, although they questioned whether the number of mental health care staff was sufficient to meet mental health needs in a timely way.

Previous deaths at HMP Doncaster

23. Mr Kernaghan was the 17th prisoner to die at Doncaster since November 2018. Of the previous deaths, eight were self-inflicted, six were from natural causes and two are awaiting classification. There have been nine deaths since Mr Kernaghan's death. Three were self-inflicted deaths and six were from natural causes.

24. There are no similarities between our findings in the investigation into Mr Kernaghan's death and our investigation findings for the previous deaths.

Key Events

25. On 17 November 2006, Mr Daniel Kernaghan was sentenced to life imprisonment for murder. After spending time in a number of prisons, he was transferred to Doncaster on 15 November 2018.

26. At his reception health screening, a nurse noted Mr Kernaghan's significant medical history. He had a history of epilepsy, vascular dementia, ischaemic heart disease, a mini stroke, type 2 diabetes, hypertension, chronic kidney disease, pancytopenia (a low blood cell condition), constipation, bladder issues, deafness and frailty (he used a walking frame or stick to get around).

27. Mr Kernaghan saw healthcare staff frequently and he had daily social care support. Appropriate care plans were created to manage his long-term conditions. Healthcare staff referred him to hospital when his health deteriorated.

28. In November and December 2019, he was treated in hospital for pneumonia and then for vasovagal syncope (fainting due to low blood pressure).

29. On 8 January 2020, Mr Kernaghan collapsed as he was leaving his cell. The duty nurse attended and noted there were no injuries and his observations were normal. On 17 January, he was taken to hospital after slipping as he tried to get into a wheelchair. X-ray results showed no signs of injury and he returned to Doncaster later that day. Mr Kernaghan had two further falls on 13 February. He refused to use walking aids.

30. Healthcare staff made a referral to a physiotherapist but in March 2020, a severely restricted regime was introduced in response to the COVID-19 pandemic and, as a result, no physiotherapist referrals were progressed.

31. Healthcare staff created a falls care plan to support Mr Kernaghan's mobility. His falls assessments were reviewed on 19 June, 2 July, 15 July and 18 August.

October 2020

32. On 4 October, Mr Kernaghan was taken to hospital after falling and complaining of severe hip pain. X-rays showed he had not fractured his hip. The hospital discharged him to the prison in the early hours of 5 October, despite the discharge letter saying that he had failed an occupational therapy and physiotherapy assessment (designed to ensure the safety of a patient returning to their usual residence) and needed to be admitted to a medical ward. No recommendations were made to the prison GPs about medication or ongoing monitoring.

33. When Mr Kernaghan returned to Doncaster on the morning of 5 October, a prison paramedic reviewed him and noted that, due to Mr Kernaghan's frailty and reduced mobility, he would be discussed at the nurse handover meeting and needed a social care team review. A prison GP completed a review for Mr Kernaghan's medication and pain relief. Social care staff noted that his mobility was decreasing. He was struggling to bear weight on his right leg, was becoming more confused, deteriorating in frailty and was incontinent.

34. On the evening of 5 October, the prison paramedic saw Mr Kernaghan again because he was complaining about pain in his left side. The paramedic checked his vital signs and noted that his National Early Warning Score 2 (NEWS2 - a clinical tool to monitor clinical deterioration) was 8, indicating that he required urgent clinical evaluation. He arranged for an ambulance to take Mr Kernaghan to hospital.

35. At hospital a CT scan did not show any injuries and his NEWS2 score had decreased to normal levels. The hospital discharged him to Doncaster very early on the morning of 6 October. There is no evidence that the hospital provided a discharge letter

36. When Mr Kernaghan returned to Doncaster, prison healthcare staff arranged for his vital signs to be monitored daily. They noted that his health had deteriorated further and that he was unable to feed himself or follow instructions because he was confused. A daily living plan was created as Mr Kernaghan needed two members of staff and a walking frame to transfer him in and out of bed.

37. Prison healthcare staff questioned whether Mr Kernaghan had been safely discharged from hospital as he was in pain when he tried to move, needed help eating and drinking and was more confused. An occupational therapist completed an assessment and noted that Mr Kernaghan was trying to move around independently because he did not understand the increased risks of him falling. His falls risk assessment was increased to high.

38. On 7 October, a nurse saw Mr Kernaghan at the request of prison staff and noted that his blood pressure was low, and he looked dehydrated and unwell. His NEWS2 score was 4. He was taken to hospital where hospital doctors diagnosed sepsis (a life-threatening condition), as a result of a lower respiratory tract infection. Mr Kernaghan's condition deteriorated in hospital and he was placed on end of life care. However, his condition later improved, and he returned to Doncaster on 21 October. Prison healthcare staff increased the level of his monitoring.

39. On 28 October, a prison GP saw Mr Kernaghan after he complained of upper abdominal pain. The GP requested urine and blood tests and referred him to the hospital falls clinic and radiology department.

40. On 30 October, the prison paramedic arranged for Mr Kernaghan to return to hospital because his vital signs were outside the normal range. Hospital staff discharged him the next day and said that prison healthcare staff should consider an advance care plan as recurrent hospital admissions were not in Mr Kerrigan's best interests, given his frailty and dementia. Mr Kernaghan was isolated for 14 days on his return to prison because he might have been exposed to COVID-19 in hospital.

November 2020

41. Senior healthcare managers at Doncaster reviewed Mr Kernaghan's care. He needed one to one care at all times due to his increased falls. A crash mat was placed at the side of his bed.

42. On 3 November Mr Kernaghan had an unwitnessed fall and was found on the floor. Staff helped him get back into bed. There is no evidence that healthcare staff checked his vital signs or that they used the Glasgow Coma Scale (GCS - a tool which is used to check the level of consciousness following a head injury).

43. Mr Kernaghan had another fall on 6 November and was seen by a prison GP, who noted that Mr Kernaghan had no injuries. However, his blood pressure was low and healthcare staff monitored him.

44. On 7 November, Mr Kernaghan had a COVID-19 test. The result was negative.

45. On 9 November, a prison GP examined Mr Kernaghan after his social care assistants said he was deteriorating. The GP checked his observations and asked the prison paramedic to arrange for Mr Kernaghan's transfer to hospital for palliative care.

46. Mr Kernaghan was admitted to hospital and diagnosed with pneumonia. He was placed on end of life care and died on 11 November.

Contact with Mr Kernaghan's family

47. When Mr Kernaghan was admitted to hospital in November 2019, a Prison Custody Officer (PCO) was appointed as the prison's Family Liaison Officer and made contact with Mr Kernaghan's next of kin, his sister. The PCO remained in contact with Mr Kernaghan's sister when he was admitted to hospital on other occasions and contacted her again when he was taken to hospital on 4 October 2020. She remained in contact and telephoned her to inform her of Mr Kernaghan's death and then arranged a cremation at his sister's request. The prison made a contribution towards the funeral in line with Prison Service instructions.

Post-mortem report

48. The post-mortem examination found that Mr Kernaghan died from community acquired pneumonia. He also had vascular dementia and a fractured hip which did not cause but contributed to his death.

Findings

Clinical Care

49. The clinical reviewer found that much of the healthcare Mr Kernaghan received was equivalent to that which he would have received in the community.

50. She said that appropriate care plans were put in place for his long-term conditions and they were reviewed regularly, and care was provided in line with NICE clinical guidance. He was appropriately discussed regularly in multi-disciplinary team meetings. Appropriate measures were also put in place to protect Mr Kernaghan from the COVID-19 pandemic.

51. Appropriate social care plans were also implemented following Mr Kernaghan's transfer to Doncaster, and the clinical reviewer noted that it is evident that social care staff treated Mr Kernaghan with respect and acted as an advocate for him. Health and social care personnel took Mr Kernaghan's dementia diagnosis into account, he was appropriately seen by the Learning Disabilities nurse, his mental capacity was appropriately assessed when he refused medication and food, and interventions were put in place to promote his independence.

52. The clinical reviewer was also satisfied that Mr Kernaghan was appropriately transferred to hospital during acute deteriorations in his physical health.

53. However, the clinical reviewer considered that high NEWS2 scores were not always acted on appropriately. We recommend:

    The Head of Healthcare should ensure that all staff are trained in the escalation process of elevated NEWS2 scores and are aware of the need for a review and documentation of forward planning to ensure appropriate, timely and responsive care during times of acute deterioration.

54. The clinical reviewer was also concerned that there were failings in the management of Mr Kernaghan's falls, and a lack of advance care planning and appropriate end of life care. She concluded that in these respects the care Mr Kernaghan received was not equivalent to that which he would have received in the community.

Falls management

55. Mr Kernaghan sustained numerous falls, complicated by his dementia, frailty and incontinence of urine. The clinical reviewer found that the care provided to him in relation to his mobility, falls risk and post-falls interventions was not always within the recommendations set out by NICE guidance. Following unwitnessed falls and the potential for a head injury, healthcare staff did not monitor neurological signs, and so risked missing early opportunities of care for a head injury.

56. The clinical reviewer also noted that, although Mr Kernaghan was prescribed pain relief for his leg pain there is no evidence that healthcare staff monitored his levels of pain, using an observational tool as recommended by NICE guidance. This approach would have allowed for ongoing assessment and monitoring of Mr Kernaghan's levels of pain and ensured appropriate and timely interventions.

57. In addition, although the post-mortem found that Mr Kernaghan had sustained a hip fracture, this was not identified by healthcare staff and it is not clear from the records when this injury happened.

58. We recommend:

The Head of Healthcare should review the falls policy and ensure that healthcare staff know the process and procedures for post falls to ensure appropriate timely interventions for those at risk of falling in line with NICE guidance.

Advance care planning and end of life care

59. Although Mr Kernaghan had a DNACPR in place (meaning he did not want to be resuscitated if his heart or breathing stopped), the clinical reviewer was concerned that healthcare staff did not discuss an advance care plan with him at any time, nor was this considered during complex case reviews.

60. Following Mr Kernaghan's discharge from hospital on 1 November, the hospital advised that an advance care plan should be implemented to reduce Mr Kernaghan's frequent hospital admissions, as these were not felt to be in his best interests. Despite multi-disciplinary meetings being held at Doncaster following this, there is no evidence that an advance care plan was discussed.

61. The clinical reviewer considered that if a named older persons' nurse had been assigned at Doncaster, this would have allowed for an overview of Mr Kernaghan's differing needs and specialised nursing care. She also noted that a member of the healthcare team said at interview that end of life care was not available at Doncaster, although the Deputy Head of Healthcare said that it was.

62. We recommend:

The Head of Healthcare should review the provision of advance life planning and end of life care to ensure appropriate care plans and resources are in place and are delivered in a timely and responsive way, so that all prisoners who are at the end of life are treated with respect and dignity.

The Head of Healthcare should review dementia care including training for healthcare staff to ensure robust holistic care is provided to prisoners with dementia and allow further appropriate end of life care planning when required.

Discharge from hospital on 5 October 2020

63. The clinical reviewer was concerned that, following an admission to hospital on 4 October, Mr Kernaghan was discharged to prison despite hospital therapists stating this would not be a safe discharge. As a result, he required a further admission to hospital that evening.

64. She also noted that the prison did not always receive discharge letters from hospital following an attendance by Mr Kernaghan, and that this could have had the potential to delay ongoing management of his care.

65. We recommend:

The Head of Healthcare should contact the discharge team at Doncaster Royal Infirmary to raise the issue regarding Mr Kernaghan's discharge from hospital on 4 October 2020, to enable the discharge team to investigate Mr Kernaghan's unsafe discharge back to HMP Doncaster.

The NHS Commissioners should address with secondary care providers why Mr Kernaghan was discharged back to HMP Doncaster on 5 October 2020, despite hospital therapists advising against this.

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