

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Hung Hoang, a prisoner at HMP Berwyn, on 23 January 2020**

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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

**OGL**

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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 Hung Hoang died in hospital of heart failure on 23 January 2020 while a prisoner at HMP Berwyn. This was caused by sepsis (a life-threatening reaction to an infection) which in turn was caused by bacterial endocarditis (an infection in the inner lining of the heart). He also had liver cirrhosis (scarring of the liver caused by long-term liver damage) which did not cause but contributed to his death. Mr Hoang was 58 years old. I offer my condolences to those who knew him.

The clinical reviewer found that the clinical care that Mr Hoang received at Berwyn was good and equivalent to that which he could have expected to receive in the community.

However, I am concerned that there was an inconsistent approach to using interpretation services for Mr Hoang, whose main spoken language was not English.

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**

**November 2021**

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# Summary

## Events

1. In September 2018, Mr Hung Hoang was sentenced to nine years in prison for causing grievous bodily harm and sent to HMP Altcourse. He was transferred to HMP Berwyn on 21 March 2019.
2. In November, he was diagnosed with an ulcerated lesion on his tongue caused by a fractured tooth which was subsequently removed but was found not to be cancerous.
3. On 5 January 2020, Mr Hoang reported that he had been vomiting for three weeks and that it was painful when he did so. Healthcare staff recorded his observations (temperature, blood pressure and pulse rate), which were normal, and arranged for a prison GP to review him the next day.
4. On 6 January, the prison GP reviewed Mr Hoang, suspected that he had lung cancer and referred him to hospital.
5. On 14 January, Mr Hoang felt unwell and was short of breath. Healthcare staff noted that Mr Hoang had a heart murmur and arranged for him to go to hospital straightaway.
6. He remained in hospital, where he died of heart failure caused by sepsis on 23 January.

## Findings

7. The care that Mr Hoang received at Berwyn was equivalent to that which he could have expected to receive in the community.
8. However, there was an inconsistent approach to using interpretation services when healthcare staff reviewed Mr Hoang. The clinical reviewer made several recommendations about healthcare administration which the Head of Healthcare will need to address.
9. We are satisfied that officers informed healthcare staff when Mr Hoang was unwell.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff use appropriate interpretation services when they review prisoners with limited English language skills.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Berwyn informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
11. The investigator did not visit HMP Berwyn due to the COVID-19 pandemic. She obtained copies of relevant extracts from Mr Hoang's prison and medical records.
12. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Hoang's clinical care at the prison.
13. The investigator interviewed one prisoner on 7 September and a prison officer on 2 February 2021. The clinical reviewer conducted joint interviews with the investigator. The interviews were conducted by telephone due to the restrictions in place during the COVID-19 pandemic.
14. We informed HM Senior Coroner for North Wales (East and Central) of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. Our family liaison officer contacted Mr Hoang's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not reply.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

## **Background Information**

### **HMP Berwyn**

17. HMP Berwyn is a newly built prison that opened in 2017 in Wrexham, North Wales, and holds 2,106 prisoners. Healthcare services at the prison are provided by Betsi Cadwaladr University Health Board (BCUHB). GP services are provided by Gables Medical Health Offender Limited which provides nineteen sessions a week. They also provide an out-of-hours service.

### **HM Inspectorate of Prisons**

18. The most recent inspection of HMP Berwyn was in March 2019. Inspectors noted that overall, the quality and governance of the integrated health provision was very good. They considered that clinical environments were clean and sufficiently equipped to meet the needs of the population. They noted that a wide range of primary care services was available and waiting times were acceptable.

### **Independent Monitoring Board**

19. 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 29 February 2020, the IMB reported that HMP Berwyn had had more consistent leadership and commended the Governor in continuing to achieve progress and improvement at times of uncertainty.

### **Previous deaths at HMP Berwyn**

20. Mr Hoang was the sixth prisoner to die at Berwyn since March 2018. Of the previous deaths, three were from natural causes and two were drug-related deaths. Since Mr Hoang died, there has been one more death from natural causes at Berwyn, caused by COVID-19. There are no similarities between our findings in the investigation of Mr Hoang's death and those of the previous deaths.

## Key Events

21. On 7 September 2018, Mr Hung Hoang was remanded to HMP Altcourse, charged with causing grievous bodily harm. On 4 March 2019, he was sentenced to nine years in prison and remained at Altcourse.
22. On 21 March, Mr Hoang was transferred from HMP Altcourse to HMP Berwyn. Mr Hoang's medical records stated that his first language was Cantonese.
23. On 24 May, Mr Hoang complained that when brushing his teeth in the mornings, there was a lot of mucus from his nose. A prison GP examined Mr Hoang but did not identify any mucus. A nasal spray was prescribed, and the prison GP noted that if Mr Hoang needed another GP appointment, it should be a double appointment to include Language Line, an interpretation service.
24. On 15 October, Mr Hoang complained that his tongue was painful. A prison GP reviewed him and noted that he had an ulcerated lesion on his tongue. The GP suspected cancer and referred him to hospital.
25. On 7 November, an oral surgeon diagnosed the lesion as a traumatic ulcer, related to a fractured tooth. The surgeon organised a biopsy to rule out cancer.
26. On 18 November, Mr Hoang's fractured tooth was removed. It was noted in Mr Hoang's medical record that he was given post-operative instructions verbally and in writing. It is not clear from the medical record if Language Line was used.
27. On 12 December, an oral surgeon saw Mr Hoang and told him that his tongue had healed well, and that the biopsy showed his ulcer was not cancerous.
28. A prisoner at Berwyn said at interview that during December, Mr Hoang told him that he was very concerned about his health and that he was passing blood in his faeces. He also said that Mr Hoang asked an officer for help, but he refused to believe Mr Hoang and said that it was probably due to constipation. The officer told the investigator that on or around 6 January, Mr Hoang mentioned blood in his faeces and that it was reported to healthcare staff.
29. On 5 January 2020, Mr Hoang reported that he had been vomiting for three weeks, that it was painful when he vomited, that he could drink water but had lost his appetite. Healthcare staff noted that an officer had also reported Mr Hoang was unwell. They recorded his observations and weight and arranged for a prison GP to review him the next day. Staff noted it was difficult communicating with Mr Hoang due to his limited English and so used interpreting software.
30. At about 11.30am the next day, a prison GP reviewed Mr Hoang but noted that it was difficult to assess him due to his limited English. Later that day, the GP reviewed Mr Hoang again, using a telephone interpreting service. The GP asked Mr Hoang to provide sputum samples. He suspected lung cancer and referred Mr Hoang to hospital.
31. On 9 January, Mr Hoang complained of headaches, toothache, tongue pain and recent chest pains. A healthcare support worker said that she would liaise with a doctor to see if a follow-up appointment was needed.

32. At 5.14am on 11 January, a prisoner told officers that he was concerned about Mr Hoang. At 9.55am, a nurse examined Mr Hoang in his cell and noted that he spoke limited English. The nurse took Mr Hoang's observations, noted that he had a high temperature, was coughing a lot and offered him paracetamol, which he declined. At 10.46am, the nurse contacted an out-of-hours prison GP for advice. The GP advised to give Mr Hoang paracetamol and to ring back in a few hours. At 3.44pm, the nurse took Mr Hoang's observations again and noted that he was still ill. At 5.19pm, the nurse spoke to the out-of-hours GP again, who advised sending him to hospital straightaway. Mr Hoang travelled to hospital by taxi. Later that night, he was discharged from hospital and returned to Berwyn.
33. At 10.30am on 14 January, at 10.30am, Mr Hoang felt unwell and was short of breath. A nurse took his observations and asked a prison GP to review him. At 11.38am, the prison GP reviewed Mr Hoang, noted he had a heart murmur and advised sending him to hospital straightaway. After an escort risk assessment was completed, Mr Hoang travelled to hospital by taxi and was admitted. Two officers escorted Mr Hoang and a single cuff was used to restrain him. The single cuff was removed and replaced with an escort chain at 4.45pm, when Mr Hoang was admitted to hospital. Log in details for the interpretation service, The Big Word, were noted on the risk assessment form.
34. Mr Hoang died in hospital on 23 January.

### **Contact with Mr Hoang's family**

35. On 23 January, Berwyn appointed an officer as the family liaison officer (FLO). Later that day, the FLO telephoned Mr Hoang's named next of kin, whom he had listed as his sister. She spoke little English and so the officer spoke to her daughter, who said that Mr Hoang was not related to them and that they did not want the prison to contact them.
36. The FLO spoke to Mr Hoang's contacts listed on his prison telephone account. They explained that Mr Hoang's family had cut ties with him after his conviction.
37. Mr Hoang's funeral took place on 29 January. The prison contributed towards funeral costs, in line with national instructions.

### **Support for prisoners and staff**

38. After Mr Hoang's death, a governor debriefed the escorting officers when they returned to the prison. The officers had the opportunity to discuss any issues arising, and support was offered.
39. The prison posted notices informing other prisoners of Mr Hoang's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case Mr Hoang's death had adversely affected them. A prisoner was told in person.

## **Post-mortem report**

40. The post-mortem report established that that Mr Hoang died of heart failure. This was caused by sepsis which was caused by bacterial endocarditis. Mr Hoang also had liver cirrhosis which did not cause but contributed to his death.

# Findings

## Clinical care and interpretation services

41. The clinical reviewer found that the care that Mr Hoang received at Berwyn was of a good standard and was equivalent to that which he could have expected to receive in the community.
42. He concluded, however, that there was an inconsistent approach to using interpretation services when healthcare staff reviewed Mr Hoang. Sometimes, healthcare staff offered the service, and at other times they did not, even when healthcare staff noted that it was difficult communicating with Mr Hoang because of his limited English. We make the following recommendation:  
  
**The Head of Healthcare should ensure that healthcare staff use appropriate interpretation services when they review prisoners with limited English language skills.**
43. The clinical reviewer also made several recommendations about improving healthcare administration, which the Head of Healthcare will need to address.

## Responding to clinical concerns

44. Although it is not related to the cause of Mr Hoang's death, a prisoner and an officer gave different accounts of what happened when Mr Hoang reported to prison staff that he had blood in his faeces. The prisoner said that Mr Hoang told him in December that he had blood in his faeces and that when he told an officer about this, the officer dismissed it as constipation. The officer said that Mr Hoang told him on or around 6 January that he had blood in his faeces and prison staff reported this to healthcare staff. Mr Hoang's medical record in part supports what the officer said. It says that on 5 January, an officer reported to healthcare staff that Mr Hoang was unwell. However, it did not specifically refer to blood in his faeces.
45. Although we are unable to confirm that the officer specifically reported to healthcare staff that Mr Hoang experienced blood in his faeces in December, we are satisfied that healthcare staff reviewed Mr Hoang in December, and that an officer (not necessarily the officer in question) contacted healthcare staff on or around 6 January about Mr Hoang's ill health.

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