SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2023] FAI 22

HAM-B351-20

DETERMINATION

BY

SHERIFF COLIN DUNIPACE

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

into the death of

XI BIAO HUANG

HAMILTON, 11 APRIL 2023

[1] The sheriff, having resumed consideration of the cause, finds and determines that in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") the following:

(1) In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):

That the death of Mr Xi Biao Huang, (hereinafter referred to as "Mr Huang") born 7 September 1963, occurred at 09.22 hours on 19 September 2017 within Dungavel House Immigration Removal Centre, Strathaven (hereinafter referred to as "Dungavel").

(2) In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

No accident occurred causing the death of Xi Biao Huang.

(3) In terms of section 26(2)(c) of the 2016 Act, (the cause or causes of death): That the cause of death was:

1(a) Ischaemic Heart Disease[1].

(4) In terms of section 26(2)(d) of the Act (the causes or causes of any accident resulting in the death):

No accident caused the death of Mr Huang.

(5) In term of section 26(2)(e) of the 2016 Act, (any precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in the death being avoided):

There were precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in the death being avoided.

(a) Upon the arrival of Mr Huang at Dungavel he should have been subject to a full and proper medical assessment, including the taking of vital signs.

(b) The examining practitioner should have been provided with all available documentation received by GEO Group from the Home Office, and in particular the forms IS.91, IS.91R, IS.91RA and IS.98[2] relating to Mr Huang.

(c) Professional interpreting services should have been utilised at the point of the initial assessment to ensure full and proper communication with Mr Huang upon his arrival at Dungavel.

(d) Full medical assessments of Mr Huang should have been carried out on 8 and 9 September 2017. Professional interpreting services should have been

utilised for the purposes of these assessments. Proper records should also have been maintained

(e) A full medical examination should have taken place on 10 September 2017 prior to continuing the deceased's medication for a further protracted period.

(f) A full examination and assessment of the deceased should have taken place within an available adjacent private consulting room on 18th September 2017. This should have included the use of the 12 lead ECG equipment. This assessment should have utilised appropriate interpreting services

(6) In terms of section 26(2)(f) of the 2016 Act, there were a number of defects in any system of working which contributed to the death.

(i) The system in place relating to the use of interpreters within the establishment was vague, haphazard and ambiguous and contained insufficient specification in relation to factors to be considered when deciding on the appropriate means of communication with non-English speakers.

(ii) The policy operated within the establishment governed by the Detention Services Operating Manual[3] relating to interpreters/translations contained insufficient guidance to allow proper reasoned decisions to be made regarding the use of fellow detainees as opposed to professional interpreters.

(iii) The Minor Ailment Policy for Dungavel, otherwise known as the "Homely Remedy" [4]policy operated by Med Co at the relevant time was

insufficiently detailed or well documented to operate safely. In addition it was not properly implemented by staff.

(iv) The system for booking GP appointments was not properly documented.

(v) There was insufficient demarcation between the system of medical consultation and medication dispensation which took place at the same location.

(vi) Medical consultations took place in an inappropriate location as opposed to an appointed consulting room

(vii) The standard of medical record keeping within the establishment was not compliant with the requirements of the Nursing and Midwifery Council Code.

(7) In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death), there are a number of facts which are relevant to the circumstances of the death:

None

(8) In terms of section 26(1)(b) and 26(4) of the 2016 Act I have recommendations which might realistically prevent other deaths in similar circumstances arising from the evidence.

(i) All medical assessments, and particularly clinical examinations should be carried out with the use of a professional interpreter where the detainee does not speak fluent English. Whilst the nature of the establishment may mean that it would not be possible or practicable to use professional interpretation services for every interaction with a detainee, the use of fellow detainees and/or members of staff to provide interpreting services should not be permitted for medical

consultations and assessments when detainees present with complaints. Professional interpreting services should always be utilised in a medical context, except in emergency situations.

(ii) The terms of the Detention Services Operating Manual and Detention Centre Rules 2001 (DSOMD)[5] should be amended to address the existing lack of guidance in relation to the situations in which it is acceptable for the Centre to use other detainees, visitors or staff to interpret. Proper guidance should be provided to assist staff in relation to the situations in which it would be appropriate for them to exercise their discretion in this regard.

(iii) In the event that it is necessary and appropriate to utilise the services of a fellow detainee rather than a professional interpreter, then the reason for this decision should be properly recorded and documented. There should also be a system in place regulating the retention and availability of these records.

(iv) All medical assessments of and interactions with patients, should be fully recorded and maintained in a manner that ensures that they are available to future healthcare staff when they are interacting with or examining patients. Training on the requirements of the Nursing and Midwifery Council Code[6] should be considered to remind nurses of their professional obligations notwithstanding any employer based rules. Appropriate documentation should be provided to the medical staff enabling them to comply with the requirement of the aforementioned Code.

(v) The "Homely Remedy" policy should be amended to ensure it is cross-referenced to other health records to safeguard that any such remedies dispensed cannot continue for a protracted period without a further clinical examination. The KardEx system, if it is to be maintained, should be amended to ensure that it enables the dispensing practitioner to complete details of; the patient's reported complaints and symptoms; relevant medical history; observations; diagnosis; and treatment plan. In each case a separate record should be maintained on an appropriate Physical Care record outlining the symptoms, diagnosis and the results of any physical examinations which should be maintained with the patient's clinical record.

(vi) The policy of using retired GPs on an ad hoc basis should be reviewed to ensure that there is always sufficient cover in place to meet existing demand. Where an appointment is made to see a GP this appointment should take place as arranged and in the event that it cannot proceed an explanation should be provided, and a further appointment arranged as soon as possible. Alternative appointments should immediately be offered as soon as possible thereafter.

(vii) There should be a clear demarcation between areas set aside for the purposes of dispensing and supervising medication and also areas earmarked for the presentation of patients for assessment and treatment.

(viii) All clinical assessments should take place within an appropriate consultation room, to ensure the confidentiality and privacy of the patient. They should not continue to take place in open corridors in view of other detainees.

(ix) Any person carrying out assessments should ensure that in doing so they have full access and recourse to the existing medical records of the patient in all but emergency situations. It would be appropriate for each consultation room to have computer access so that medical records of detainee's are always available to medical staff at the time of assessments.

(x) Access to the IS.91 and other Home Office forms should routinely be made available to all medical staff, and in particular to the admissions nurse.

(xi) The issuing of language flashcards should be mandatory to ensure that all detainees are able to quickly point to their language to assist in the identification and sourcing of the appropriate interpreting services.

(xii) There should be a system of automatic triggers for GP assessment following repeat presentations within a short time frame. Such a frequency of attendances should ensure that the patient is automatically registered for a GP appointment within a reasonable time frame.

(xiii) Where doctors are asked to continue prescriptions under the "Homely Remedy" policy, it should be the default position that this should trigger an appointment for assessment by the GP unless there are compelling reasons to believe this is not necessary.

(xiv) Receiving custody staff should receive training in processing arriving detainees to ensure that accurate details in relation to languages spoken are obtained.

NOTE

Introduction

[2] This was a discretionary inquiry held under section 4 of the Act, the death having occurred in Scotland in circumstances giving rise to serious public concern. The Lord Advocate has decided it therefore to be in the public interest for an Inquiry to be held into the circumstances of the death. The procedures to be followed in such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiries Rules) 2017. The purpose of such an Inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. Section 26 requires the sheriff to make a determination and section 26(2) sets out the factors relevant to the circumstances of death insofar as they have been established to the satisfaction of the sheriff and which are set out above. The Sheriff has to be satisfied on balance of probabilities of whether there were any precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in the death being avoided or defects in the system of working which contributed to the death and whether there is a reasonable possibility that any recommendations made may prevent deaths in similar circumstances in the future. The scope of the inquiry therefore extends beyond simply establishing the facts relevant to the death of Mr Xi Biao Huang. It is also to ascertain whether steps could be taken to ensure that future deaths occurring in the circumstances or similar circumstances could be prevented, and to restore public confidence and allay public anxiety arises from the circumstances of the death of Xi Biao Huang.

The determination is limited to the matters defined in section 26 of the Act which also provides that the determination shall not be founded on in any judicial proceedings of any nature, thus encouraging full and open exploration of the circumstances of a death.

The proceedings and the parties

[3] In terms of the procedural history, this Inquiry went through various preliminary hearings at Hamilton Sheriff Court on a number of occasions before the Inquiry itself which took place on 16, 17, 18, and 19 August 2022 and on 17 and 30 November 2022. The various parties were represented as follows:

1. Mr R Hill, Procurator Fiscal Depute, represented the Crown;
2. Ms C Connelly (Counsel) represented the next-of-kin;
3. Ms E Toner (Counsel) represented GEO Group UK Ltd;
4. Ms C Fraser (Counsel) represented Med-Co Secure Healthcare Services Limited;
5. Mr J Mulgrew represented Nurse B;
6. Mr G Burton represented Nurse R;
7. Ms Harris represented Nurse M;
8. Ms Thomson represented the Home Office

The sources of evidence

[4] A joint minute of agreement, a copy of which is attached hereto as Appendix A, was entered into by the parties. I thereafter heard evidence from fourteen witnesses

who all gave evidence in person on the following dates at Hamilton Sheriff Court, namely:

1. Mr Zhiming Huang: 15 August 2022
2. Ms Miao Dan Li: 15 August 2022
3. Nurse R: 15 August 2022
4. Dr William Ramsay: 15 August 2022
5. Nurse B: 16 August 2022
6. Nurse G: 16 August 2022
7. Nurse H: 16 August 2022
8. Mr Kit Wu: (remotely) 17 August 2022
9. Dr Steven Conroy: 17 August 2022
10. Ms Helen Adams: 17 August 2022
11. Nurse Karen Simpson: 19 August 2022
12. Dr Stephen Hearns: 19 August 2022
13. Dr Karen Hogg: 17 November 2022
14. Nurse Julie Bowmaker: 17 November 2022

Affidavit evidence was also led in respect of the witness Ms Sarah Lynch. At the conclusion of the evidence all parties submitted full and detailed written submissions, with some parties submitting supplementary submissions. I have summarised these submissions, which I considered in full in the course of preparing this determination. I am extremely grateful to all parties for their assistance in the preparation and professional conduct of this Inquiry.

The legal framework/the purpose of this Inquiry

[5] This Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 govern Fatal Accident Inquiries. The purpose of the Inquiry in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the Inquiry is not to establish blame or civil or criminal liability. The process is inquisitorial in character. The Procurator Fiscal represents the public interest at the Inquiry.

[6] As regards the circumstances, the sheriff must make findings regarding:

(a) when and where the death occurred;

(b) when and where any accident resulting in the death occurred;

(c) the cause or causes of the death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which –

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

(f) any defects in any system of working which contributed to the death or any accident resulting in the death; and

(g) any other facts which are relevant to the circumstances of the death.

[7] In terms of section 26(4) the sheriff is entitled to make recommendations regarding:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working; and

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

Factual Background

[8] Having heard the evidence and considered the Joint Minute prepared between the parties I found the following facts to be established.

(1) Mr Xi Biao Huang (the deceased) was born in China on 7 September 1963 and was a Chinese national. Following his relocation to the United Kingdom he initially resided alone prior to residing with his son Mr Zhiming Huang and his wife. At various points he also resided with his daughter (not a witness to this Inquiry).

(2) On 31 August 2017 he was detained by Immigration Officers in Bootle, Merseyside on suspicion of having committed immigration offences. He was initially detained within Campsfield House Immigration Removal Centre, Kidlington where he was medically assessed at 21.00 on 1 September 2017. During the course of this initial health assessment Mr Huang was noted to have never had a serious injury, illness or operation and was not taking medication.

His blood pressure was considered to be high although his pulse was normal. He declined a consultation with a GP at that time.

(3) On 5 September 2017, Mr Huang was transferred to Dungavel House, Immigration Removal Centre, Strathaven, (hereinafter referred to as "Dungavel") where he was to be detained on the authority of the Home Office. He was housed in room 1, Hamilton House within that Immigration Removal Centre.

(4) Dungavel House Immigration Removal Centre at the relevant time was operated by GEO Group UK Ltd (hereinafter referred to as "Geo Group") under a contract between the Home Office and Geo Group. The prevailing documentation governing the operation of Immigration Removal Centres, including Dungavel at that time was the Detention Services Operating Manual and Detention Centre Rules 2001 (hereinafter referred to as "DSOM"). This Manual relating to health care arrangements in place at Immigration Removal Centres stated that "the Centre must ensure that appropriate decisions are made about the use of interpreters or translated materials on a case by case basis. The level of communication must be adequate to ensure correct clinical outcomes"[7].

(5) The Geo Group sub-contracted Med-Co Secure Healthcare Services Limited (hereinafter referred to as "Med-Co") to provide healthcare services at Dungavel in 2017. Medical centre staff at Dungavel are employed by Med-Co Secure Healthcare Services Ltd.

(6) Mitie Care and Custody Ltd. have operated Dungavel House Immigration Removal Centre since September 2021.

(7) Mr Huang's name was initially recorded incorrectly as Mr Gen Bue Wong upon his detention. His date of birth was also incorrectly recorded. Whilst detained by the Home Office on 31 August 2017, Mr Huang was served with forms IS.91, [8] IS.91R,[9] IS.91RA, [10]1S.98,[11] and IS.98A,[12] by Home Office staff. It was recorded on both the IS.91R and the 1S.98 documents that the contents of these documents had been explained to Mr Huang in the Cantonese language. Mr Huang was in fact a Taishanese speaker, although he had some understanding of Cantonese. His knowledge of English however was restricted to a few words of greeting. Mr Huang had no knowledge of the Mandarin language.

(8) When Mr Huang arrived at Dungavel Centre on 5 September 2017, hard copy forms IS.91RA and IS.91R were provided to Geo Group by the Home Office Escorting Contractor. It was recorded on the IS.91 document that Mr Huang spoke Cantonese. These forms were provided to the Custody Officer, but they were not produced onwards to the healthcare worker who performed the initial assessment on Mr Huang upon his arrival at Dungavel.

(9) On his arrival at Dungavel Mr Huang's first and only language was recorded by the Dungavel GEO staff in their records as being Mandarin. In the GEO Group Discharge Report, his first and only language was also recorded as

being Mandarin. Mr Huang does not speak, nor has he ever had any understanding of Mandarin.

(10) Mr Huang was medically assessed upon his arrival at Dungavel on 5 September 2017 at 04.30 hours. This assessment was carried out by Nurse R. It was recorded by Nurse R that she had used "Big Word" translation service during this assessment. The Big Word Interpreting Services Ltd (hereinafter referred to as "Big Word") are a translating and interpreting company who provide these services to government departments and commercial organisations. They have a contract with the GEO Group to provide interpreting services to them. As part of this contract they also provide interpreting services to Med-Co staff. The costs of these services are however invoiced to GEO Group. There is no record of any such translation services being provided by "Big Word" at the relevant time and on the date specified by Nurse R. Invoices produced by "Big Word" do not record their services as having been engaged for either Mandarin or Cantonese translation during this consultation.

(11) Some basic physical readings were taken from Mr Huang by Nurse R, and his blood pressure was recorded as being 127/84. This reading would not normally give any cause for concern and did not do so at the relevant time. It was also recorded that Mr Huang declined a consultation with a GP, and that he was noted to have no medical issues. He indicated a desire to see an optician, and he saw an optician on 6 September 2017. The Reception Screen Audit

Form[13] which contained information such as referrals for GP or nurse appointments, and fitness for detention was not completed.

(12) Mr Huang presented to healthcare with a medical complaint at 23.30 hours on 8 September 2017. He attended alone for that consultation and he was seen at that time by Nurse R. This consultation took place at the "hatch" without any interpreting services being utilised, albeit these were available. The "hatch" was an area of the health centre where patients attended for the dispensation of medication and also to consult with nursing staff. It was between a room and the corridor with a stable type door, the top half of which was opened to allow discourse with patients and to facilitate the dispensing of medication. Nurse R stated that when Mr Huang attended he held his nose and mimicked a sneeze. Nurse R took no physical observations and there was no verbal exchange between the patient and the nurse, both parties in fact being incapable of communicating in the other's language. As a result of this interaction a diagnosis of a cold and nasal congestion was made by Nurse R and Mr Huang was prescribed Paracetamol and Sudafed for a cold and nasal congestion in terms of the establishment's "Homely Remedy" policy. No record was maintained of this consultation in relation to the presenting complaint, symptoms, diagnosis, treatment or management plan. No entry was placed in the clinical records of Mr Huang.

(13) Med-Co had in existence a policy in place at the time which permitted nurses to prescribe medications for Minor Ailments, and which was referred to

as the "Homely Remedy" policy for a period up to 3 days[14]. A "Homely Remedy" was an over-the-counter medication for minor ailments. There was a list of such remedies which included medications such as Paracetamol, Sudafed, Peptac and Gaviscon. After three days in terms of the policy a GP was required to prescribe any further medication. Details of such prescriptions were recorded on a document headed: "Approved PRN & PGD Meds Only drugs from the approved list may be issued, maximum duration of treatment for PRN Three Days".[15] This document was referred to by the relevant nurses and other parties as the "KardEx". On the KardEx entry for the consultation on 8 September 2017 at 23.30, it was recorded that the presenting complaints were "cold" and "nasal congestion".

(14) The establishment also operated a system of paper records headed "PhysicalCare records" on which could be recorded details of interactions with patients following consultations. In relation to the aforementioned interaction on 8 September 2017, no such PhysicalCare record was raised or completed. It is likely at that time that Mr Huang may have been experiencing a myocardial infarction at that time when he presented for assistance.

(15) Mr Huang presented with a further medical complaint approximately two hours later at 01.20 hours on 9 September 2017 when he was accompanied to the healthcare centre by a Detainee Custody Officer, and he was again seen by Nurse R. On this occasion a PhysicalCare record was completed by Nurse R[16]. Nurse R has noted that Mr Huang was: "Brought to Healthcare complaining of

feeling unwell BP 139/87 p69 SATS 99% on air Temp 36 degrees BM 6mls". These physical readings were unremarkable and would not particularly give any clinician any cause for concern.

(16) Mr Huang also attended at the healthcare centre on two further occasions on 9 September 2017, namely at 09.10 and 14.35 hours. No PhysicalCare Records have been maintained in relation to either of these consultations, although there are KardEx records which show that Mr Huang was seen by two different Nurses at these times. During these consultations the presenting complaints were recorded as being "Common Cold" and "Cold" respectively. On both occasions paracetamol and Sudafed were dispensed to Mr Huang. No records have been maintained to confirm whether Mr Huang was physically examined or whether he was present and able to communicate with the assistance of an interpreter. There was no evidence that any interpreter was used on either occasion. Mr Huang also attended at the healthcare centre on 10 September 2017 at 09.00 when his presenting complaint was again recorded as being "cold", and he was prescribed paracetamol and Sudafed. No separate PhysicalCare record or any other record of this meeting was separately maintained in relation to this attendance.

(17) The separate "Recording sheet for Prescription Sheet"[17] applicable to Mr Huang (although wrongly ascribed to Gen Bue Wong) also recorded that medications were prescribed to Mr Huang on 10, 11, 12, 13, 14, 15, 16, 17 and

18 September 2017. No separate records were maintained of any consultations that might have taken place at the time of these dispensations.

(18) On 10 September 2017, Dr William Ramsey, a self-employed, retired, locum General Practitioner sub-contracted by Med-Co reviewed Mr Huang's medical notes and also prescribed him Paracetamol and Sudafed[18]. No clinical assessment, physical examination or indeed any form of verbal or physical interaction took place between Dr Ramsay and Mr Huang at that time. The prescription by the doctor was made purely on the basis of the written and verbal information supplied to him by nursing staff.

(19) Mr Huang presented with a further medical complaint at 15.00 hours on 18 September 2017 when he attended at the healthcare centre, this time accompanied by his room-mate Mr Kit Wu. On this occasion he was assessed by Nurse B. In this task Nurse B was assisted by Nurse G who was present and who provided a "second opinion". At that time Mr Huang was assessed whilst standing at the dispensing hatch. No physical examination took place at that time, nor were any observations or vital signs taken. Neither Nurse B nor Nurse G had recourse to the medical records of Mr Huang which were kept in a nearby adjacent room at the time of the consultation. No use was made of the adjacent consultation room. No use was made of the twelve trace ECG equipment maintained in that consultation room.

(20) During the course of her interaction with Mr Huang, Nurse B communicated at all times with him using his room-mate Mr Kit Wu as an

interpreter. Mr Wu attempted to communicate that Mr Huang was suffering from chest pain, and that he had pain under his arms and toothache. It is again likely that at the time of this presentation that Mr Huang was experiencing a cardiac event. No PhysicalCare record was maintained in respect of this consultation although a record was placed on the KardEx, stating that he presenting complaint was “Gastric” and that PepTac was prescribed for this. No record was made of the presenting complaint, symptoms, examination results, vital signs, and diagnosis or treatment plan.

(21) The Detention Services Operating Manual[19] relating to Interpreters/Translations states, "It is acceptable for the Centre to use other detainees, visitors or staff to interpret for other detainees, provided that both parties agree." The Manual further states, "With regard to medical matters it must be for the doctor or other healthcare team member to take a view on whether an interpreter is necessary. Other detainees or members of staff may also assist if the detainee is content with such an arrangement”.

(22) At around 08.25 on 19 September 2017, Mr Huang was found in bed by his room-mate, Mr Wu, who upon checking him, found that he was unresponsive. Using the telephone in the hallway outside the room, Mr Wu alerted Detainee Custody Officer Jacqueline Brown who alerted Detainee Custody Officer Alex Raeside who attended room 1, Hamilton House and found Mr Huang lying in bed. He was again found to be unresponsive. His forehead was cold to the touch and his lips and fingertips were beginning to turn blue.

His neck, chest and arms were however warm. Detainee Custody Officer Raeside raised an emergency code blue alarm and commenced Cardiopulmonary Resuscitation. Detainee Custody Officer Raeside was joined by Detainee Custody Officer Majid Nazir.

(23) A code blue alarm is an emergency medical assistance call used when someone is not breathing. A 999 call was made and paramedics in East Kilbride received instructions to attend at Dungavel House Immigration Removal Centre at around 08.31 hours.

(24) Nurses G and M attended immediately and found Mr Huang to still have some warmth in his body. Nurse G noted Mr Huang as having no pulse and noted that he was unresponsive. He commenced Cardiopulmonary Resuscitation and the use of defibrillator on Mr Huang. This indicated that Mr Huang was asystolic.

(25) Around 08.53 hours paramedics Lorna Weir, Colin Mitchell and Susan Ferguson arrived and took over CPR. Paramedics also performed an ultrasound after attempting various treatments. Life was pronounced extinct at 09.22 hours on 19 September 2017.

(26) Mr Huang was conveyed to the Queen Elizabeth University Hospital where a Postmortem examination was carried out on 26 September 2017. The cause of death was given as 1a) Ischaemic Heart Disease. Crown Productions 2, 3 and 4 are copies of the Postmortem Report, Toxicology Report and Supplementary Postmortem report respectively.

(27) The post mortem examination also revealed that there was significant natural disease in the heart, in the form of ischaemic heart disease. Examination of the coronary arteries showed multi-focal severe atheromatous narrowing (furring/hardening) of two of the major branches (left anterior descending and cirumflex). With subsequent microscopy showing evidence of intraplaque haemorrhage and confirming luminal thrombus, the heart itself showed of both resolving/healing infarction (with microscopic appearances of around one to two weeks in duration) and also acute changes of around a day or so in duration. Postmortem examination could not provide an absolute definitive age of an area of infarction, but the degree of natural disease in the heart would provide an explanation for death and indicate that there has been a "heart attack" around two weeks prior to death with features of a further "heart attack" around a day or two prior to death.

(28) In September 2017, the medical assessment of new detainees at Dungavel House Immigration Removal Centre was done on a paper form. The healthcare team at Dungavel House Immigration Removal Centre now use a patient management system called Vision. This is the system operated by NHS Lanarkshire. It was not in place in September 2017. At that time the healthcare team utilised paper medical notes.

(29) The healthcare team at Dungavel require to request medical notes from prisons (if applicable) and the resident's GP practice using the resident's name,

date of birth and a signed mandate from the resident. The procedure in this respect was the same in September 2017.

(30) The healthcare team at Dungavel have unlimited access to a live telephone translation service procured by the centre operator, at that time GEO Group. In September 2017 the interpreting service utilised was "Big Word" procured by GEO Group. Med-Co staff had access to these services. There were no resource issues in relation to the use of interpreting services by Med-Co.

(31) Med-Co has a matrix of mandatory training which all nurses are required to undertake and update as necessary. In September 2017 all nursing staff received annual face to face basic life support training. They now receive immediate life support training which is a higher level of training.

(32) Med-Co undertake audits of medical notes and prescriptions. In 2017, audits of medical notes were undertaken by Med-Co bi-monthly of five sets of medical notes and five prescriptions for three clinicians. Now monthly audits are undertaken.

Summary of the witnesses' evidence to the Inquiry

The following witnesses gave evidence to the Inquiry.

Witness One

Mr Zhiming Huang

[9] The son of the deceased, namely Mr Zhiming (known as Jimmy) Huang advised the Inquiry that the date of birth of his father had been incorrectly recorded and was in

fact 7 September 1963. His father had arrived in the United Kingdom from China and had lived alone for two years prior to living with him and his wife. He had been living there when he was detained on 31 August 2017 and taken to a police station in St Annes, England, prior to his removal the following day to a Detention Centre in Cambridge. The witness confirmed that his father spoke very limited English, being confined to using phrases such as "hello" or "hi". His natural language was Taishanese, which is a variety of the Chinese language native to the Taishan region. This language is distinct from but is related to Cantonese, which his father could speak and understand to a limited degree. However he was clear that his father could not understand or speak Mandarin.

[10] Whilst in the Cambridge Detention Centre, the witness regularly spoke to his father by telephone, and he specifically recalled his father telling him on 1 September 2017 that he was feeling unwell. His father was transferred from Cambridge to Dungavel on 5 September 2017. Whilst there the witness continued to have regular telephone contact with his father during which they would discuss his father's health. His father regularly complained of pain in his upper body, neck and face, and stated that his ears were painful. He also intimated that he was experiencing toothache and pain under his arms. His father informed him that whilst he had seen nurses whilst in Dungavel that he had not seen any doctors. He also confirmed that there had been no interpreters present when he spoke to the nurses, although he did mention that on one occasion his Malaysian room-mate, Mr Kit Wu, had interpreted for him. His father advised him that he had received some medication from the nurses, which had

improved his condition, and also informed him that an appointment with a doctor had been arranged, but when he had attended for this appointment that the doctor had not appeared at the appointed time, and this appointment had been re-arranged. No explanation had been provided to him for this failure on the part of the GP to attend the appointment. He also mentioned to his son that he was due to be transferred to Manchester on 19 September 2017.

[11] The witness advised the Inquiry that his father told him on several occasions that he had asked staff to see a doctor given that the pain he was experiencing was unbearable at times, and indeed on one occasion he had stated that the pain was so bad that he didn't think he would make it to Manchester. He described the pain as being in the area of his heart and underneath both arms. He also indicated that his head, neck, teeth and ears were all painful. He recalled that on another occasion his father had told him that he couldn't speak to him as he was so short of breath. The witness had concluded that his father's health was deteriorating by the day, but he had not personally attempted to contact the detention centre regarding these concerns as he hadn't been aware of the procedure to enable him to do so. He regretted that he had not been able to contact them to advise them of his concerns and fears for his father.

Witness Two

Ms Miao Dan Li (Known as Nikita) (28)

[12] The second witness to give evidence to the Inquiry was Ms Miao Dan Li (known as Nikita) who was the wife of Zhimming Huang, and therefore daughter-in-law of

Mr Huang. This witness also recalled that Mr Huang was living with them in Liverpool on 31 August 2017 when he had been detained for alleged immigration offences. He had subsequently been moved to Dungavel.

[13] Whilst Mr Huang was in Dungavel the witness confirmed that she and her husband maintained regular telephone contact with him, speaking at least five times a day. When he called he would often state that he was quite scared. He regularly discussed his health and advised them that he was suffering from chest pain, and was experiencing pain under his arms as well as muscular pain in his arms and back. He also suffered from neck pain, earache and toothache. He mentioned having seen a nurse, and going on occasions to a nurses' room for medication. He stated that whenever he did so there were no interpreters present and he could not communicate with them until he met his room-mate who spoke Cantonese, and who interpreted for him when he received his medication. He mentioned that he had an appointment to see a doctor but that the doctor had not turned up, and there was no explanation given for this. The witness also recalled a specific incident when Mr Huang indicated that he believed that his health problems may have been caused by a lack of exercise, but that when he had attended the gym in the establishment that the staff had pointed to his chest and waved him away. He had interpreted this as the staff preventing him using the gym due to a perceived heart problem.

[14] The witness confirmed that her father-in-law spoke Taishanese, a Chinese dialect totally different from Cantonese, although he did have some understanding of

Cantonese. However she was also aware that he had no knowledge of Mandarin whatsoever, and his English skills were also almost non-existent.

Witness Three

Nurse R

[15] Nurse R was the first member of staff to give evidence. She was a nurse of 25 years' experience. In September 2017 she was employed by Med-Co, who are the out-sourced private company providing health services within Dungavel. This organisation are completely separate from the NHS.

[16] The witness recalled that on 5 September 2017 she was working as a staff nurse within Dungavel, when a male, whom she subsequently ascertained was Mr Huang, was brought in to allow her to provide an initial health assessment. She explained that the process for detainees arriving at Dungavel was for them to see a custody reception officer employed by GEO Group prior to being brought to meet her to provide a health assessment. The reception officer would record several of the individual's details such as their height, weight, language, religion and any other relevant information, such as security issues, and this information was recorded on a paper admission sheet, a copy of which she was provided to her. At that time there was no computer access to records, although she advised that staff now had access to a computer system known as Vision, which is an NHS software system containing all of the known NHS medical records of an individual.

[17] The witness referred to the Home Office admission movement sheet[20] she had received from the reception officer, which she noted was erroneously completed in the name of Mr Gen Bue Wong, although she was aware that it did relate to Mr Huang. The witness observed that the first page of this document was created on 3 September 2017 at 14.50. In the form there was handwriting which contained details of Mr Huang's height and weight. It also recorded "L – Mandarin No English". The witness believed that the handwriting was completed by the admission officer, and that it had already been completed by the time that she received the form.

[18] The witness confirmed that she was responsible for completion of the Med-Co Detainee Healthcare Record[21]. Again this form was erroneously completed in the name of Gen Bue Wong. The witness completed the "Consent to Treatment" form and the "Dungavel IRC Reception screen"[22] form was also completed by her. It was completed by the witness at 04.30. She confirmed that this document contained information in relation to the individual's date of birth, age, nationality etc. She acknowledged that there appeared to be a number of errors on this form. In relation to relevant family information it appears to have been erroneously entered that Mr Huang had no next of kin. Further the date on the "Consent to Treatment" aspect of the document bore to have been signed on 5/9/71. The witness confirmed that in relation to the sections headed "Languages Read" and "Languages Spoken" that she has recorded "Mandarin" for both sections. The witness believed that she had been given this information when she was assessing Mr Huang (who at that time she would have

known as Mr Wong), and that it may have come from the Home Office form completed by the Admission Officer.

[19] The witness was also referred to Home Office document which bore to be a Detainee Cover Sheet[23] relating to the deceased. The witness indicated that she was unfamiliar with this production, which had not been made available to her prior to her assessment of the deceased. The witness acknowledged that this form contained a section allowing for the entry of "Language Spoken", where the word "Cantonese" had been handwritten. The witness referred to a document which was headed "CID Notes Alan",[24] confirming that this was not a document that she was familiar with. She acknowledge that this document stated "Subject requires an interpreter for ETD – none available tonight". The witness also noted that the document referred to "Big Word" being used as interpreters. [25] Further on the form IS.91R[26] reference was made to "Languages being spoken" as being "Cantonese." This document also referred to the fact that the contents of the notice had been explained in Cantonese by a "Big Word" Interpreter on 31 August 2017. The witness accepted that this documentation referred to Mr Huang as being a speaker of Cantonese and not Mandarin, but confirmed that she had never previously seen these documents which had not been made available to her when she had conducted her initial assessment.

[20] In relation to the "Detainee Healthcare Record", the witness confirmed that the first substantive page within this document competed by her was the "Consent to Treatment" form which the witness confirmed was completed in her own handwriting. The form was signed by Mr Huang and the witness, although she acknowledged that

the date of the signature was patently wrong, (being recorded as 3/9/71 as opposed to 3/9/17).

[21] The witness also confirmed that the form to confirm whether an individual wished or did not wish any medical intervention was not completed, and she inferred from this that he had in fact agreed to have medical treatment. The witness indicated that she had communicated with Mr Huang whilst completing the appropriate forms utilising the "Big Word" Translation service. She stated that she had followed the normal procedure for assessing an individual who had entered the establishment in that she would ask them about their language, although in this particular case she couldn't specifically recall what language Mr Huang had indicated that he spoke.

[22] The witness stated that she had phoned "Big Word" interpreting services, and that she did so using the phone number printed in each room. The procedure in place was that she had been assigned a code that she could use to access the system as an employee of Med-Co. There was also a separate code for each language, and that having dialled the telephone number this code was entered whereupon the call went through to a speaker of the chosen language. This process was not however always instantaneous, and sometimes there might be no interpreter available. On this occasion the witness recalled that the interpreter had translated her questions and the answers provided by Mr Huang.

[23] The witness confirmed that the form completed by her contained a series of typed questions, and that she addressed these questions with Mr Huang, hand writing any responses provided. In addition there were a number of physical observations

recorded, namely blood pressure/ temperature and height, weight and BMI as well as blood pressure which she had taken. The witness considered that the observations taken by her at that time were unremarkable. The form also noted that Mr Huang had been asked whether he wished to make a GP appointment, and it had been recorded that he had declined to make any such appointment. By way of explanation the witness stated that the option to see a doctor was voluntary, and her understanding was that if an individual had any medical issues then they would seek an appointment. In the present instance she had noted that Mr Huang had requested a referral to an optician, which the witness understood took place after she had undertaken her usual procedures.

[24] The witness confirmed that on the form that she had recorded "Mandarin" for languages read and spoken, and also that the interpreting organisation "Big Word" had been used. The witness could not specifically remember what language was actually used, and believed that she may have copied the reference to Mandarin from the handwritten notes produced to her at the time of the deceased's admission. The witness could not explain why the "Big Word" invoice prepared for GEO Group did not show that any interpreting services had been utilised that day either for Mandarin or Cantonese interpreting services. The witness felt sure that this must have been an error as she was certain that she had used these interpreting services, although she could not be certain in what language the interpreter had spoken to Mr Huang. The witness suggested that had she not used the interpreting service that she would not have been able to ascertain that Mr Huang had poor eyesight and needed glasses. An Opticalcare

record[27] was completed in respect of Mr Huang (whose name was at that time recorded as "Wong") on 6 September 2017. The witness also felt that whilst she could not recall what language was used, that there was never any indication that the interpreter could not understand the deceased, although as she did not speak Mandarin or Cantonese, she could not understand what was said between the parties.

[25] This form completed by the witness also recorded that the detainee had read the policy statement and that the text box stating "The detainee has read the policy statement" was ticked. The witness observed that the adjacent box used to indicate that the policy statement had been read via an interpreter was not ticked, but she believed that this was simply an error of transcription on her part.

[26] The witness confirmed that this form was completed on 5 September 2017 at 4.30pm, (although the form itself appears to have stated that it was signed at 4.30am). The following pages of the document[28] indicated that Mr Huang had declined a medical appointment, and the subsequent references to Mental Health Assessment; Current Presentation; Objective Assessment Conclusion/Action Points and In-Possession Risk Assessment were not completed. The form was not signed by a General Practitioner, and the final page headed "Reception Screen Audit"[29] was also not completed by the witness

[27] The witness advised that her next interaction with Mr Huang was when he presented himself to her again at "the hatch" on 8 September 2017 at around 23.30, in relation to what she noted as a complaint of cold symptoms and nasal congestion. She recalled that he had attended with her on his own, and there were no other individuals

present at that time. Given that they could not converse, their only interaction had been when he had pointed to his nose and sniffed. From these gestures the witness inferred that he had cold symptoms and nasal congestion and proceeded accordingly to utilise the "Homely Remedy" policy, prescribing paracetamol and Sudafed. No physical examination took place and no vital signs were recorded by Nurse R.

[28] The witness referred to a document headed "Approved PRN and PGD Meds"[30]. This was a copy of entries from what was subsequently referred to by the witnesses as the "KardEx" system. This document contained sections to enable records to be maintained of the following details in a tabular form, namely:

- "Date";
- "Time";
- "Drug";
- "Dose";
- "Batch No";
- "Complaint"; and
- "Given By".

The witness stated that this policy effectively comprised a log of "over the counter" medications which could be prescribed by nurses. Nurse R completed the first entry on this log on 8 September 2017 at 23.30. When he had attended on 8 September 2017 Nurse R confirmed that no physical observations, such as blood pressure taken by here at that time, explaining that as she believed that Mr Huang was displaying cold symptoms that there would have been no necessity to carry out any such observations.

The witness could not recollect how long she spent with him at that time as the KardEx was the only place that this interaction was recorded, and there was no section for such a record to be maintained. No PhysicalCare record was completed by the witness, who also recalled that no interpreter or fellow detainee was used to translate given that she had not considered that she had required one.

[29] The witness also advised that she saw Mr Huang the following day at around 01.20 and confirmed that on this occasion she had filled in a PhysicalCare record form on 9 September 2017.[31] She noted that the surname of Mr Huang was still erroneously noted as being "Gen Wong" on this form. From the information on this form the witness could say that on that date that Mr Huang was brought to healthcare by the orderly officer complaining of "feeling unwell". The witness decided on this occasion to undertake physical observations to ascertain how he was presenting, and having done so she had concluded that he was suffering from a continuation of his cold symptoms. The witness recalled that the initial information in relation to the complaints of Mr Huang came from the presenting officer and not Mr Huang who clearly could not communicate with her. She advised that "Big Word" was not used again because of the way Mr Huang was presenting, and the fact that he never attempted to communicate with her. In relation to the observations taken by the witness, she observed that the blood pressure of Mr Huang as recorded, namely 139/87, was slightly abnormal although she stated that this reading would not be a concern to her given that this did not constitute hyperstolic hypertension. As well as blood pressure the witness recalled that she checked several of Mr Huang's vital signs including his pulse, blood saturation

levels and temperature. She had advised him that she needed to take his blood pressure using hand gestures. He had complied with this request and had put his arm out to facilitate this. Again the witness confirmed that "Big Word" interpretation services were available had she concluded that she required them. She had not so concluded.

[30] The witness acknowledged that she had not maintained a similar PhysicalCare record for the deceased's first visit on 8 September 2017, (which she ascribed to her having simply administered medication) although she accepted that any such notes would be helpful for any later interventions. She had not believed that they were necessary on the first occasion given her belief that sufficient details were recorded on the back of the KardEx system, as stated above, although she acknowledged that there was less information contained on the KardEx than could be recorded on the PhysicalCare Records. The witness expanded upon her understanding of the existing "Homely Remedy" Policy, the terms of which policy meant that nurses were able to prescribe "over the counter" medication, such as paracetamol to patients for three days, following which, if further medication was still required they would refer the matter to a doctor.

[31] The witness re-iterated that whilst during her initial assessment of the deceased on 5 September 2017, she had used interpreting services, but accepted that in her subsequent dealings with him that she had not, explaining that because she had initially admitted him she was aware that he did not have any underlying medical conditions, although she did accept that individuals can develop such conditions over time. Accordingly, whilst she accepted that an interpreter might have been useful during her

subsequent meetings with Mr Huang, when she saw Mr Huang on 8 and 9 September 2017, she had not felt that they were needed, a clinical judgement call she had felt entitled to make.

[32] The witness conceded that her record keeping had not been adequate, and in all likelihood had not complied with the Nursing and Midwifery Council Code although she maintained that notwithstanding the lack of recording that her medical assessment of Mr Huang had been thorough in its terms on each occasion.

[33] The witness acknowledged that had she been aware of the deceased's cardiac condition, and had he presented with such a complaint that she would have given him an ECG, and administered aspirin and a GTN spray. However she had felt no need to do so as he never presented with any other complaints, and indeed whenever she saw him he always presented as being very calm.

[34] In respect of further events in September 2017, the witness stated that her recollection of events was not good, and to an extent that it was based on references to records, although she did specifically recall him attending upon her on a second occasion. She accepted that in a statement that she gave to the police at the time that she may have stated that she did not have any great recollection of the man, and accepted that she had a vague recollection of dealing with him, although most of her recollection was based on reference to the medical records.

[35] The witness was referred to the Report by Julie Bowmaker, lodged on behalf of the deceased's next-of-kin. [32] She had prepared this report in her capacity as a nursing expert. The witness was advised that this witness's opinion was that the standard of

care provided to Mr Huang fell below the expected standards, that there were systemic failures, and there was also a failure by her to properly assess Mr Huang on 8 and 9 September 2017. It was also said that there had been significant failings in the documentation maintained within the establishment. The witness acknowledged that the standard of documentation was not good, and that she would not have met the requirements of the prevailing Nursing and Midwifery Council Code in place at the time, although she disputed that the standard of care had not been adequate.

[36] The witness said that Mr Huang sometimes relied upon Mr Kit Wu to communicate for him. Mr Wu, had shared a room with Mr Huang for a few days. In general terms she observed that detainees brought friends and fellow detainees to communicate for them. She stressed however that if this was not effective then they would be provided with an interpreter.

[37] The witness stated that if she had entertained concerns regarding the condition of Mr Huang then she would have secured an appropriate medical attendance, and if it was suspected that he had cardiac problems then she would have utilised a GTN spray and ECG prior to immediately arranging a hospital attendance. On the occasion of her interaction with Mr Huang on 8 September 2017 she confirmed that that her initial observations had caused her no concerns. Mr Huang had not complained of anything other than touching his nose, and there was no indication of any chest or other pain. He had not pointed to his upper body, face or teeth, nor to under his arms. Further there was nothing to suggest any shortness of breath on his part. The witness advised the Inquiry that she had dealt with heart failure cases on many times before and was well

aware of the symptoms to look out for, such as clamminess, sweating, complaints of pain in the back and arms, and generally looking unwell. The witness confirmed that Mr Huang displayed none of these symptoms, nor did he complain of shortness of breath or being in pain on either 8 or 9 September 2017.

Witness Four

Dr William Ramsay

[38] Dr William Ramsay is a retired medical General Practitioner who had qualified as a doctor in 1977. Since September 2017 he had acted as a locum GP at Dungavel, employed by Med-Co to provide general medical services on a part-time basis. He provided clinical sessions at Dungavel three to four times a week depending on holidays.

[39] This witness confirmed that he had never met the deceased, but that he had been asked at one point to provide a prescription for a continuation of a "Homely Remedy". He described his understanding of this policy as being a prescription for minor ailments, which nurses can provide for three days, after which the policy at Dungavel required that they refer the matter to a doctor. The witness confirmed that he never personally assessed Mr Huang, but that at the end of his clinic on 10 September 2017 he had been asked by a nurse if he could prescribe further "Homely Remedies" for Mr Huang. The witness stated that he had looked at the KardEx and observed that several nurses had already prescribed Sudafed and paracetamol to the deceased. The witness noted from the records that Mr Huang had declined a medical appointment and that this document

had been countersigned by his colleague Dr Jamieson. This meant that Mr Huang had not seen a GP whilst in Dungavel.

[40] The witness stated that the conclusion he drew was that Mr Huang had declined to see a GP, that he had no medical history of any note, and that the previous records indicated that he had complained of having a common cold. He completed the Prescription Chart, prescribing Sudafed and Paracetamol on 10 September 2017. In relation to Sudafed, he prescribed this with a "Start Date" of 10 September 2017 and a "Stop Date" of 17 September 2017. A review date was fixed in respect of this medication. The witness also prescribed paracetamol with a Start Date of 10 September 2017 and a Review Date of 10 October 2017. The witness confirmed that in reviewing Mr Huang, he was completely reliant on the observations of the nurses, which he was happy to do given their diagnosis of a common cold. In this regard the witness also confirmed that he had had access to the "PhysicalCare" record completed by Nurse R which had referred to Mr Huang as having attended at healthcare on 9 September 2017 at 01.20. The witness referred to the presenting complaint that Mr Huang was "Feeling unwell" and noted the physical readings which were taken. He considered that these were unremarkable and they would not have caused him any concerns. The witness confirmed that he felt no need to examine Mr Huang himself, although this option had always been open to him, adding that if an individual presented with a minor ailment to a nurse, he would take it as read that the recorded assessment was correct.

[41] In relation to the ongoing prescription provided to Mr Huang the witness confirmed that he would normally expect Sudafed to be prescribed for seven days and

paracetamol for about ten days. He pointed out that these drugs are available over the counter. However if the symptoms persisted for more than four or five days then he would expect that nursing staff would arrange for the patient to see a GP for a personal assessment. He observed that this had not happened in this case. He also considered that a prescription of ten to eleven days for a cold treatment was a bit long, and that seven days would probably have been appropriate. He did however also state that in relation to the paracetamol that he left this prescription open for a month, between 10 September 2017 and 10 October 2017, with the Sudafed being left open for seven days between 10 September and 17 September 2017.

[42] The witness noted that the expert evidence available suggested that Mr Huang may have suffered a myocardial infarction two weeks before his death and also forty eight hours before his death. He was also advised that Mr Huang had complained to his family of chest pain, and suffering pain in his back and under his arms, as well as experiencing earache and toothache. The witness confirmed that had he been made aware of these symptoms, that this would have caused him concern, given that these symptoms were consistent with ischaemic heart conditions.

[43] In relation to the use of interpreting services, the witness said that it was common for patients in Dungavel not to speak English as their first language, or indeed for them not to have any English at all. Accordingly he used interpreting services nearly every working day. The witness confirmed that there were three doctors on the rota working at Dungavel, and therefore there was a doctor on duty there every day. They operated a morning clinic when they attended to see patients who asked to see a GP, as

well as dealing with referrals from nursing staff and seeing patients who were being reviewed. The witness also confirmed that the patient's case notes and the KardEx were made available to the doctors when seeing patients.

Witness Five

Nurse B

[44] Nurse B is a registered Mental Health Nurse at Dungavel, having qualified in February 2007. She had commenced employment at Dungavel in April 2007, which was her first post after qualifying.

[45] The witness stated that her role was to work predominantly within a multi-disciplinary team of health care professionals in the health care department as a mental health nurse. Her primary role was to assess patients and provide overall care in relation to mental health issues as well as undertaking general nursing duties, including dealing with routine admissions into the healthcentre and operating general nursing clinics.

[46] The witness stated that she knew the deceased, Mr Huang (whom she also knew as Mr Wong), and was aware that she had had interactions with him on 11, 15, 16, 17 and 18 September 2017. On some of these dates she had given him medication, namely paracetamol and Sudafed for complaints of a cold and nasal congestion, although no separate healthcare records had been maintained in relation to any of these meetings. The witness confirmed she saw Mr Huang when he attended to receive the medication prescribed at "the hatch", namely the window where patients came for medication. This

hatch led to a secure pharmacy on the other side from where she would dispense the medication. The procedure was that patients would be given specific times to arrive, and on their arrival they would show an identification card, which would be checked and if appropriate the medication would then be dispensed. The witness confirmed from the information recorded on the KardEx that she had dispensed medication to Mr Huang on the specified dates.

[47] The witness also confirmed that if she was concerned that a patient presented with serious symptoms that she would try to identify that condition and to deal with them appropriately. In relation to Mr Huang she was unaware of any other interventions with him apart from issuing the medication, with the exception of her interaction with him on 18 September 2017. On that date she recalled that he had attended with his friend, Mr Kit Wu, just after 3pm. Mr Wu had described Mr Huang's complaint. After a series of questions Mr Huang was provided with medication which was contained within the room off the corridor. The witness confirmed that nursing staff can utilise the adjacent consulting rooms for private consultations and emergencies or if for example the patients were very emotional, however she had not considered that any of these criteria applied to Mr Huang and her entire interaction with him was from behind the hatch.

[48] She observed from the KardEx records that on 18 September at 15.00 she had prescribed 10 mls of Peptac for gastric symptoms. She noted that her signature recorded that at the time of dispensing indicated that she would have had sight of the eight entries above her own on the KardEx. She also understood that a subsequent

prescription had been written up by a Doctor after that. At the time Peptac was given to the deceased it was the first of that type of medication to be given. He had previously received medication for cold symptoms, but when she had asked further questions of Mr Huang there appeared to be further symptoms which were more gastric in nature. The witness accordingly saw the new presentation as being for a different complaint to the previous cold symptoms.

[49] The witness recalled that she has seen the PhysicalCare Record from Nurse R, and as such she was cognisant of the full extent of the nursing records for the patient. At that time the records were maintained in a paper format and were not kept in computerised form. They were kept in a filing cabinet separate to the medication records, in an adjacent room just around the corner from the dispensing room. The witness recalled that she saw these records after she had dealt with the deceased.

[50] The witness noted that Mr Huang complained of feeling unwell, although she indicated that it was difficult to understand exactly what that meant. She did however conclude from his appearance that there were no great concerns "jumping out" at her. The witness communicated with Mr Huang through Mr Wu, although she was well aware that "Big Word" interpreting services was an available option for her to use, and she knew how to do so by choosing a language and an interpreter who would become available by telephone. At that time she chose not to use their services.

[51] The witness confirmed that she was aware of the terms of the Detention Services Operating Manual relating to health care arrangements operating at Immigration Removal Centres noting that it stated that:

> "The Centre must ensure that appropriate decisions are made about the use of interpreters or translated materials on a case by case basis. The level of communication must be adequate to ensure correct clinical outcomes"[33]

And also that it further stated:

> "It is acceptable for the Centre to use other detainees, visitors or staff to interpret for other detainees, provided that both parties agree"[34]; and
>
> "With regard to medical matters it must be for the doctor or other healthcare team member to take a view on whether an interpreter is necessary. Other detainees or members of staff may also assist if the detainee is content with such an arrangement."[35]

The witness confirmed that she was well aware of the foregoing provisions, and of the importance of effective communication, especially given that a large proportion of the detainees in Dungavel could not speak English. She accepted that understanding patients was crucial to her role and if there were any barriers to understanding then she was aware that professional interpreting services were available. She stated that she would have no hesitation in using these services.

[52] She recalled that on 18 September 2017 when Mr Huang had attended with his room-mate Mr Wu that she had not known what language he spoke. She did however consider Mr Wu to be very articulate with well-spoken English and she was satisfied that there would no issues with utilising this channel of communication. She cross-checked the accuracy of what was being said by Mr Wu by observing various physical factors like eye contact, and head nodding, and it appeared to her that there had been appropriate responses to each of the questions asked. She considered that there was no suggestion that Mr Wu was not acting in the best interests of Mr Huang as he seemed genuinely interested in helping him which satisfied her. The witness accepted as a

general rule that it might be safer to use "Big Word" than a room-mate, and though she often used that service, in this instance, she was content to use the assistance of Mr Wu. In terms of communication the witness could not remember the language spoken by Mr Wu, although she was satisfied that there was adequate communication between him and Mr Huang. Mr Wu appeared to be describing the complaints that Mr Huang was experiencing, and the proximity and the eye contact between Mr Huang and his friend led to her understanding that it had been agreed between them that he was happy to have his friend communicate with her on his behalf.

[53] Nurse B confirmed her understanding that Mr Huang had previously presented with cold and nasal congestion symptoms, although she was unaware of any previous complaints of chest and back pain or toothache. She recalled that when Mr Huang presented with his roommate, that she considered that he was describing upper abdominal pain. She had asked him to point to where he was feeling the pain, and he had pointed to his central abdominal area and had indicated that the pain was there "and upwards". He was asked what form the pain took and indicated a feeling of burning, suggesting that it came and went. He was questioned by her for approximately five minutes, and during that time he did not suffer from any shortness of breath. There was no reference during this process to him experiencing any pain under his arms or in his shoulders or toothache. As she approached the diagnosis of Mr Huang, Nurse B stated that she was assisted by her colleague Nurse G. As a result of the descriptions of pain, the witness and her colleague Nurse G jointly decided that the presenting complaint was gastric and they decided to prescribe PepTac to assist with his

discomfort, as well as arranging for him to see a GP the following day. She stated that this appointment was entered in the GP appointment book.

[54] The witness confirmed her knowledge and experience of cardiac issues and stated that she was aware that not all heart attacks had a typical presentation, however if Mr Huang had indicated any symptoms such as chest pain, breathlessness or pain under his arms then these symptoms would have led to a further assessment.

[55] Nurse B confirmed that she never maintained any records of her meeting with Mr Huang, deciding not to do so because he did not appear to be distressed, and given that his presentation appeared to be no different from her previous interactions with him. She had no concerns regarding his complexion, and as such she decided that there was no requirement for her to take his vital signs. She did consider however that as Mr Huang had been unwell for ten days with cold like symptoms, that he merited a further professional assessment, and accordingly this was "flagged" up for the attention of the doctor next day. The witness stated that notwithstanding that she recorded this fact, she felt no need to take any further readings at that time. Nurse B stated that she made an appointment in the GP appointment book for Mr Huang to see a doctor the following day.

[56] The meeting between Nurses B and G and Mr Huang lasted about 5 minutes, which she felt was sufficient time for her to make an accurate assessment of him. In hindsight Nurse B accepted that a PhysicalCare Record should have been completed, especially as she accepted that these documents provided and communicated information to other healthcare professionals, enabling them to build up a picture of the

patient, thereby helping them to make future clinical decisions. She had not filled in this form at the time because she considered the KardEx system to be more efficient. She stated that in relation to the prescription of "Homely Remedies" that there were regularly over 200 people attending for medication, and that it would have taken too much time to retrieve the records for every patient. The witness accepted that her record keeping was inadequate, and indeed was virtually non-existent, but stated that it was in line with the company policy at the time. She accepted however it was not in compliance with the Code of the Nursing and Midwifery Council. She also confirmed that the "Homely Remedy" policy had now evolved insofar as it now ensured that if a patient was prescribed a new type of medication the practitioner required to fully document the written reasons for that prescription.

[57] The witness also stated that she advised Mr Huang through Mr Wu to return if his symptoms persisted or worsened and also to return if there was no relief from his symptoms. In particular he was encouraged to do so if he experienced further pain.

[58] The witness accepted aspects of the report by Dr Stephen Hearns[36] acknowledging that at the time the standard of record keeping was inadequate. In relation to the suggestion by Dr Hearns that the prescribing of paracetamol and Sudafed for a total of 11 days was an extensively prolonged period to be receiving treatment for a cold or viral upper respiratory tract infection without a detailed clinical review of his condition, she agreed that the position required to be flagged up to a doctor, which was why she had tried to arrange for Mr Huang to see the GP the next morning. She also accepted with hindsight, that the vital signs of Mr Huang should have been taken,

although she had not thought at the time that it was clinically necessary following the questions of her and her colleague, and indeed she concluded on balance that if the same circumstances subsisted today she probably still would not take those observations. The witness accepted again that in terms of the Nursing and Midwifery Council Code that her record-keeping fell below the standards required.

[59] The witness explained in more detail the procedure for assessment and prescription in force at the relevant time and explained that when Mr Huang came to the hatch with his colleague nearby, that she had recovered his medical records from the main office which was a few steps away around the corner. Despite the fact that these disclosed that he had previously suffered from high blood pressure this did not mean that she would automatically take his blood pressure again. She observed that the available records were in any event scant. She had recorded the presenting complaint and prescription in the KardEx, although no PhysicalCare form was completed. She felt that the most important factor was that she was ensuring that the doctor was at least seeing the patient, and she had put in the diary that there was to be a GP referral the next morning, which she did because she felt that a doctor should know that the cold symptoms had persisted for so long, notwithstanding that there appears to have been no reference to any cold symptoms at her consultation with him.

[60] The witness considered that she provided a high standard of care to Mr Huang. She had not believed that he was presenting with something that needed urgent action following her assessment. She had explained to him through Mr Wu that she was prescribing PepTac to resolve his gastric symptoms, and also told him that if his

symptoms did not improve that he was to revert to them, a direction she was satisfied that he had acknowledged and understood. The witness recalled that Nurse R was on night shift, and she remembered telling the staff at the handover about what had occurred during the shift, including with Mr Huang. She also left the notes for the doctor the next day. In relation to the "Homely Remedy" Policy (which is no longer in place) she considered that her recording at the time complied with the policy existent at the time, whilst acknowledging that this policy had now changed.

[61] The witness concluded by stating that if she had assessed his condition as being more serious or more acute or indeed if she had suspected he was having a heart attack then she would have taken him straight to the consulting room, given him some GTN spray and placed him in a comfortable breathing condition before calling a blue light ambulance, as she stated that she had previously done many times in practice at Dungavel since 2007.

Witness Six

Nurse G

[62] This witness had retired three years ago, although he had occasionally worked on an *ad hoc* basis since his retirement. He qualified as a nurse in 1999 and in September 2017 he was working at Dungavel in that capacity.

[63] The witness recalled that on 18 September 2017 he was on duty, having attended in the morning and dealt with the handovers. The other nurse on duty at that time was Nurse B. The witness recalled that Mr Huang had attended at "the hatch" where

medication was dispensed between 14.00 and 15.00 that day, and that he was not aware of ever having had any prior interactions with him. He recalled that Nurse B spoke to him through an interpreter while he was dispensing medications, and when he had finished that task he had joined in with their conversation. The presenting male had complained of discomfort in his mid-chest area, although his own observation was that he had walked in independently and had not looked unwell. He recalled that the male stated that the pain was not sharp or radiating, and confirmed that he wasn't breathless. He did not appear to Nurse G to be sweating and his pallor caused no concern. He spoke to Mr Huang through the interpreter, whom he believed was also a detainee, and whilst he could not remember much about him, he considered his English to be good. He could not be sure but he had thought that he was interpreting Mandarin as his language. Overall he thought that Nurse B had communicated well with Mr Huang throughout.

[64] The witness did not recall looking at any of Mr Huang's records and considered his role was that of providing a second, rather than a joint opinion, given his general view that it was good practice for nurses to "bounce ideas" off each other especially as Nurse B was a mental health nurse and he was a general nurse. He recalled that they were in agreement that the cause of Mr Huang's discomfort was heartburn or a gastric issue, resulting in the prescribing of PepTac under the "Homely Remedy" policy. Nurse G confirmed that he had not filled in any records at that time, believing that that this was down to Nurse B given Mr Huang was her patient.

[65] Nurse G confirmed that everyone in Dungavel had a health record which contained details of their dental records, chiropody records etc. The witness also stated that at that time that the way of recording the prescription of a "Homely Remedy" was to write on the KardEx. This system had now changed and any remedy now had to be included on the care record.

[66] At the time no vital signs were taken as it was felt by Nurse G and Nurse B that there was no clinical need to do so having regard to the physical appearance of the deceased. Mr Huang had not reported any pain in his chest, under the arms or earache or toothache. If he had done then he would have immediately been identified as having a cardiac issue, resulting in the administering of a GTN spray, aspirin, oxygen and an ECG test being carried out. An ambulance would also have been immediately summoned.

[67] Nurse G specifically recalled saying to Mr Huang that if his symptoms persisted that he was to return, and he believed that Mr Huang understood this. He did not recall Mr Huang indicating that he wished to speak to a doctor at any time. After Mr Huang and his room-mate had left Nurse G did not observe Nurse B retrieving any records, although he did recall that she made a note in the GP appointment diary.

Witness Seven

<u>Nurse H</u>

[68] This witness qualified as a nurse in 1981, and had worked in many establishments including hospitals in Glasgow and East Kilbride, as well as in Saudi

Arabia, London and Sudan. She had worked as a nurse in Dungavel since June 2017, and recalled that she had been working there on 18 September 2017. She did not however specifically recall ever dealing with the deceased. She stated that on the relevant date she had been dispensing at the hatch, as demonstrated by the KardEx, which recorded her dispensing that night between 20.30 and 21.30. The witness stated that the documentation showed a start date and stop date for medication, and in the case of Mr Huang the start date for Sudafed was 10 September 2017 and the stop date was 17 September 2017, which meant that this medication was meant to have been stopped on 17 September 2017 unless it was reviewed. It was observed by the witness that there was no indication on the chart that this had ever been reviewed.

[69] The witness accordingly accepted that her dispensing of this medication on 18 September 2017 was an oversight given it was beyond the stop date of 17 September 2017, explaining however that when she was dispensing at the hatch that the prescription chart had not been made available to her.

Witness Eight

Mr Kit Wu

[70] This witness gave his evidence remotely and through an interpreter. It was apparent that Mr Wu's English was fractured and could not be described as particularly effective. Mr Wu confirmed that he had also been a detainee in Dungavel at the relevant time, believing that he had been taken there on 12 September 2017. Whilst there he met Mr Huang, with whom he struck up a rapport. This was approximately two – three

days after he had arrived. Following his arrival he had initially shared a room with various people, but a few days later he had asked to change his room to share only with Mr Huang. Before he had changed rooms he had spoken to Mr Huang in Cantonese, and they appeared to be able to converse in that language. The witness was not aware of the Taishanese language and conversed solely in Cantonese. Mr Wu initially spent a lot of time with Mr Huang and other Chinese people, although when he moved in with him he spent more time exclusively with Mr Huang.

[71] The witness recalled that Mr Huang often spoke about his chest pain and told him that that he felt unwell and was in pain for which he was taking medication. Mr Wu felt however that he did not look too unwell. He recalled that Mr Huang had asked him to help him in his interactions with the medical staff, given that he could not communicate at all in English. Accordingly the witness assisted Mr Huang by translating for him with the medical staff, and he specifically remembered assisting him twice when speaking to medical professionals.

[72] Mr Wu specifically recalled that on 18 September 2017 he went with Mr Huang at 15.00 to see a nurse. He recalled that this was the day before he passed away. He stated that they had attended at the health centre and spoke to a nurse although he could not recall if this was a male or female nurse. He remembered translating for Mr Huang who was complaining of chest pain. He told the nurse that Mr Huang had chest pain, and particularly that his chest was uncomfortable and burning. The witness confirmed that the principal reason that he had gone with Mr Huang was to specifically inform them about this chest pain. The witness could not recall how long they spent

with the nurse at that time, but he did interpret between Mr Huang and the nurse to the best of his ability. Whilst he could not remember the individual questions asked, he did recall interpreting a number of questions from the nurse to Mr Huang, and demonstrating certain movements to assist the nurse in understanding what he was describing. In answer to one question he recalled that Mr Huang stated that he had a burning sensation and that he had chest pain, which he specifically remembered given that this was the reason Mr Huang had wanted to see the nurse. He was sure that he told the nurse about Mr Huang's chest pain and he rubbed his chest in the centre to demonstrate what Mr Huang had explained to him. He had answered many questions from the nurse, and whilst he did not remember the content of these questions exactly he believed that he had answered these properly. Thereafter the nurse provided Mr Huang with medication, which he thought was in liquid form. He could not remember whether he ever saw Mr Huang take this medication.

[73] Mr Wu recalled that later Mr Huang had told him that he was to be moved to another detention centre, and that he appeared to be somewhat stressed about this. Indeed the witness thought that he was more worried about his immigration status than his health. The next morning the witness alerted staff as Mr Huang was unresponsive in the room.

[74] Mr Wu confirmed that he had previously supplied a statement to the police on 19 September 2017 concerning the circumstances surrounding the death of the deceased. [37]He accepted that he had told the truth to the police at the time.

Witness Nine

Dr Stephen Conroy

[75] Dr Stephen Conroy qualified in 1990 and worked in Primary Care as a General Practitioner since 1994. Since 2015 he has been the Clinical Director for NHS Lanarkshire's Directly Managed Services, and since then he has also had specific responsibility for the GP Out of Hours Service and for HMP Shotts.

[76] Dr Conroy stated that he carried out a clinical review of the deceased's death on 7 February 2018 on behalf of the Prison and Probation Ombudsman thereafter producing a Report, the terms of which he adopted. [38]In order to produce this report he had been provided with the medical records of Mr Huang covering the period when he had been a detainee at Dungavel. The witness also confirmed that his report had been supplemented when he had attended at the establishment and spoke to a member of staff, although he could not recollect which member of staff he had spoken to.

[77] Having considered these records Dr Conroy noted that Mr Huang had developed a cold which had persisted for several days. He opined that the treatment of this under the "Homely Remedies" policy and by GP Prescription seemed entirely appropriate. Having regard to the KardE**x** documentation he confirmed that he had read this document which had formed part of the basis of his report. Specifically he noted that in relation to the attendance of Mr Huang with Nurse R on 8 September 2017 that the Nurse had stated that he had come to her in a corridor, and that she had noted him to be holding his nose and gesturing a sneeze. It was observed that no interpreting services were used and that this was a very short interaction. Dr Conroy stated that in

the circumstances as presented to the nurse at that time that he thought the action taken was sufficient, although he opined that if he had had access to a consulting room that he would at least have listened to the patient's chest. He would also have expected to have seen a clinical note, and certainly more information than had actually been recorded, given that the complaint as recorded simply stated "Cold". The witness confirmed that one interpretation of this might be an upper respiratory tract infection, although it could also be a reference to someone actually feeling cold. Whilst feeling cold and having a cold might amount to the same, there was always a potential for them to be different. The witness further opined that information should come from the patient, and that he would always want to speak personally to the patient. Accordingly he was surprised that no interpreting services had been used on that date.

[78] The witness further noted that Mr Huang had attended again on 9 September 2017, when he had again been seen by Nurse R, and on this occasion a PhysicalCare record was maintained. At that consultation he noted that some observations had been taken and recorded, which were acceptable and gave no cause for any concerns, although he did again consider that there might have been more of a clinical assessment, such as listening to the patient's chest. The witness emphasised the importance of maintaining records to chart the progress of the patient to ensure that any future medical assessments were based on accurate information, especially given that GPs rely on these notes to decide whether to prescribe or allow the medication to continue.

[79] Dr Conroy also referred to the further assessment on 18 September 2017 which took place at "the hatch" where prescriptions were normally dispensed to detainees.

The witness observed that it would have been good practice to retrieve available medical records before carrying out an assessment, even if they had not been immediately available. If this had been done then it would have been possible to have considered properly the matters which had arisen at the assessment on 9 September 2017. The witness further confirmed that if a consultation room was available then this should have been utilised, and that this certainly would have been the positon if the assessment lasted for more than five minutes. Dr Conroy opined that against the background of an individual being unwell for ten to eleven days, that he would have expected a more detailed assessment of the patient. He confirmed that it would have been good practice to record everything which took place at a consultation. He also confirmed that the dispensing of a prescription a day after the recorded stop date would not be regarded as adequate practice.

[80] Dr Conroy addressed the question of interpreting and confirmed that he had used such services in Shotts Prison where these facilities were also available. He had also however relied on family and friends, especially whilst operating out of hours services, although if he had the opportunity of using professional interpreting services then he would always use these. In terms of effective communication he considered this to be very important and indeed an essential feature. Accordingly he considered that if Mr Huang had been assessed without an interpreter being present then that would have given him some cause for concern.

[81] The witness also stated that if he had been aware that Mr Huang had been complaining to nurses of chest pain, burning sensations, under arm pain, toothache and

earache that these symptoms would immediately have concerned him. Further if he had been made aware at the time of the assessment that the patient was a smoker then this fact might also have caused him to make further enquiries.

[82] In relation to the "Homely Remedy" policy in place at the Centre, the witness confirmed that this was in place to assist efficiency given that it would be the only way detainees could access paracetamol for headaches/toothaches etc. He confirmed that if a member of the medical staff diagnosed that a patient was suffering from a gastric condition, then the dispensing of PepTac or a similar medication would be an appropriate medication to dispense. The witness also confirmed that a consultation of around five minutes for an assessment with questions might allow sufficient time for a diagnosis of gastric pain and the dispensing of Peptac, although it would be at the limit of what was acceptable for an assessment, and if at all possible the period of assessment should have been longer than that.

[83] The witness further confirmed that whilst he might have carried out further enquiries, his ultimate conclusion was that the medical treatment of Mr Huang had been at the very least equal to that which he might have expected in the community. He stated that Mr Huang had been dealt with appropriately on the day of presentation and noted that he had been booked in for a next day appointment with a GP. He considered this to have been an adequate and appropriate response.

Witness Ten

Helen Adams

[84] This witness has worked in Dungavel for 15 years, initially commencing as a staff nurse, before becoming a senior nurse, Deputy Manager and now Senior Manager. This witness had provided the responses on behalf of Med-Co to the Crown.[39]

[85] Ms Adams accepted that there had been poor documentation of the care that had been provided which could be viewed as inadequate care in itself. She recognised that there should have been more information placed within the medical records, but that steps had now been taken to remedy this failing.

[86] In relation to the observation that no vital signs had been checked when Mr Huang had presented at healthcare complaining of gastric pain, she stated that these were often not taken, given that the remedies in question could be obtained from supermarkets or local pharmacies.

[87] Since September 2017 Dungavel had ensured that all staff had undertaken additional training. Each member had attended an online course which requires to be undertaken every 2 years. The "Homely Remedy" policy now requires an entry being made in relation to any assessment being carried out prior to it being dispensed, a change instituted shortly after the death of Mr Huang.

[88] It had also been noted that there had been a concern that the staff had carried out CPR on a mattress rather than on a firm surface. In this regard it was confirmed that additional training was to be provided. In addition the organisation now made

available computer terminals to allow nurses to access Vision records online rather than relying on the previous paper based system.

[89] Ms Adams confirmed that the IS. 91 form (authority to detain) form contained information regarding languages spoken which should have been made available to the admission nurse at the time of the admission.

[90] Ms Adams also confirmed that a number of amendments had been made to the operating practices of the organisation which took account of the expert reports which had been prepared following the death of Mr Huang.

[91] In relation to the position regarding the medication hatch, Ms Adams confirmed that the previous situation which had existed at September 2017, whereby nursing staff would speak to detainees at the hatch, no longer existed and now as a matter of course patients will be taken to a choice of two consultation rooms for privacy and to enable staff to carry out assessments.

[92] The witness confirmed that Med-Co employs eight staff at Dungavel and used the services of six GPs including Dr Ramsay. She confirmed in relation to the "Homely Remedy" policy that this had now changed so that after three days each patient was automatically appointed for a GP consultation. At the relevant time the "Homely Remedies" were only recorded on the KardEx, because it was often very busy and accordingly medications were annotated into the notes. Now however the Vision system, which is an NHS Lanarkshire software system providing access to records including access to GP records if they are registered with a GP in Scotland, is used. It is now also the case that patient records are audited monthly whereas in in 2017 this was

carried out less than monthly. They have also instituted a new pharmacy area with a separate hatch which is manned by member of the custodial staff for safety. Ms Adams confirmed therefore that there had been a number of improvements implemented since 2017.

[93] In relation to the use of the "Big Word" service, the witness confirmed that every time they were used that there was a cost incurred, and accordingly she could not explain why the invoice relating to the 5 September 2017 did not list services for Mandarin or Cantonese or indeed Taishinese being utilised at that time.

Witness Eleven

Karen Simpson

[94] Nurse Simpson was a registered nurse who had a degree in nursing and a Masters qualification in Advanced Nursing as well as being a registered prescriber. She qualified as a nurse in 1997, and had been Health Care Manager at HMP Low Moss since 2014. The witness was instructed by the Crown to prepare a Report in relation to death of Mr Huang.[40] The witness adopted the terms of this Report into her evidence. In the course of preparing this Report the witness confirmed that she did not visit Dungavel.

[95] The witness made reference to the documentation completed at the admission of Mr Huang, and in particular in relation to Dungavel IRS Reception Screen,[41] noting that there was no free text box on the form which would allow the person completing the form to clarify his present condition. The witness also indicated that she would have

expected some recorded evidence of the interpreter having been present at the time. The witness confirmed that there were details of physical observations being recorded, which would then have been used to produce a score, which gave an evidence based structure upon which findings could be based.

[96] In relation to the interaction between Nurse R and Mr Huang on 8 September 2017, Nurse Simpson observed that Nurse R had seen him in a corridor with no interpreting services available and he had been diagnosed solely on the basis that he had held his nose and gestured a sneeze. She would not consider this to have been an adequate basis for an assessment, and further in order to have undertaken a proper physical and verbal examination, she would have expected an interpreter to have been present. She would also have expected a respiratory assessment before any drugs such as Sudafed or paracetamol were prescribed. The witness suggested that this would have been a head-to-toe assessment, including the use of a stethoscope to listen for breathing problems. Nurse Simpson further stated that this would require the asking of questions in carrying out the assessment, and in the event that a patient did not speak English she would have considered it to be unsafe to proceed in the absence of an interpreter. She would also have expected the assessment to have been done in a consultation room, and not in a corridor or at dispensing hatch. In relation to the entries on the KardEx, the witness indicated that she would have documented her examination more fully than was the case in the present instance.

[97] In relation to the note of 9 September 2017 Nurse Simpson considered that this note had not been adequately recorded, and in particular the phrase “Brought to

healthcare complaining of feeling unwell" was very vague and subjective. The rest of the notes were also unspecific, and there was no evidence of any probing into what was meant by a feeling of "unwellness". Further there was no evidence of any attempt to get to the root cause of what was actually meant by this phrase.

[98 Nurse Simpson stressed the importance of completing detailed clinical notes for retention in medical records given that they produce a chronological journal which will show the story, of the patient journey, and will also provide a clear indication of what was happening to the patient. In relation to the KardEx notes Nurse Simpson observed that in the section dealing with "Complaint" that there were no clinical assessment details. Whilst the witness recognised that the prescriptions listed are "Homely Remedies" (a phrase with which she was familiar), there should still have been assessments referred to which would be required to diagnose and treat. There should also be a limit to the number of times a patient would be prescribed these medications prior to seeking a full medical consultation.

[99] Nurse Simpson stated that Sudafed is a decongestant, the use of which suggests an upper respiratory tract or ENT infection, and accordingly that it would be imperative to document any symptoms that the patient referred to during the consultation. Concern was also expressed about the fact that there were eight entries of the same medication on the KardEx without any follow up consultation.

[100] In relation to the interaction on 18 September 2017 Nurse Simpson noted that this had also taken place at a prescription dispensing hatch and that the patient had been accompanied by a fellow detainee who was translating for both Mr Huang and the

nurses at that time. Nurse Simpson considered that it was not good practice to carry out an assessment at that location. She would also have expected a full physical and holistic examination to have taken place with an interpreter present.

[101] Nurse Simpson further considered that the reference to the complaint being "gastric" might have suggested red flags in relation to cardiac presentation, especially if there had been information regarding burning around the chest area. There should therefore have been a further assessment of the patient to probe further and if necessary to exclude these cardiac red flags. Accordingly and in the absence of these further enquiries, Mr Huang should not simply have been prescribed Peptac. She stated that she would have expected a full respiratory assessment for which she would have used a stethoscope. Whilst she agreed that such an examination would not happen in a supermarket or pharmacy selling such drugs, she distinguished those situations as being in the public domain and not in healthcare settings.

[102] In relation to those observations which had been recorded, Nurse Simpson accepted that these were largely unremarkable and were within normal parameters, although she did express a concern that the patient's systolic blood pressure was now at 139 having increased by ten between 5 September 2017 and 9 September 2017 and that his pulse was also elevated by 2. The witness explained that she would have explored why there had been an increase in his blood pressure during this period.

[103] Nurse Simpson did not agree with the suggestion that there were no grounds for concern in a situation where a patient had touched his nose and mimicked a sneeze where there was no indication of chest, back, or neck pain, given that dyspepsia is one

of the biggest indicators of cardiac difficulties. The witness confirmed therefore that she would have expected the other red flags to have been explored. This would have involved a full clinical assessment and cardiac examination and this requirement would not have changed at all in a custodial setting.

[104] In relation to the question of record keeping Nurse Simpson referred to the Nursing and Midwifery Council standards of documentation for record keeping that she stated should always be complied with. Whilst she did accept that the guidelines referenced the fact that the way in which nurses keep records is usually set by their employers, this was always subject to the overarching recognition that good record keeping was an integral part of nursing practice. [42]

[105] Nurse Simpson also referred to the fact that a proper clinical assessment involves asking questions and considering answers to get to the root cause of a differential diagnosis, a process which seeks to exclude other possibilities. She considered that using a roommate as an interpreter was not a good practice, other than in an emergency situation. Nurse Simpson emphasised the importance of effective communication, stating that if the initial assessment on 5 September 2017 had been conducted in the absence of an interpreter, that this would not have been good practice for a nurse, it not being acceptable to have a clinical examination where the treating nurse could not communicate with the patient.

[106] Nurse Simpson also stated that it would not have been good practice where a patient attended at a hatch and complained of chest pain to be prescribed Peptac and told to return and see a doctor the next day without being properly examined. She

considered that full reference should have been made to the medical records, which contained the observations including Grade One hypertension. Nurse Simpson opined that a nurse who accessed those records and saw the increase in blood pressure would on hearing about chest pain and noting an increase in blood pressure have examined those two red flags.

Witness Twelve

Dr Stephen Thomas Hearns

[107] Dr Stephen Hearns is a consultant in emergency medicine employed on a full-time basis by NHS Greater Glasgow and Clyde. He qualified in 1993 and has worked in emergency medicine since that date. He confirmed however that he had no experience of the delivery of primary care in a custodial setting. He had been instructed by the Procurator Fiscal to provide an opinion with regard to the medical care given to Mr Huang during his time in Dungavel Immigration Centre in September 2017. As a result of his investigations the witness had prepared a report,[43] which he adopted in his evidence.

[108] Dr Hearns initially referred to the KardEx document in relation to the nurses' interactions with Mr Huang. He noted that there had been a consultation with Nurse R which had taken place in a corridor when Mr Huang had held his nose and gestured a sneeze. He noted that no-one else had been present at that time and that no interpreting services had been used. Dr Hearns referred to this as a very short meeting, which he considered in general terms of patient presenting to have been inadequate. He also

observed that there were no notes available of this consultation when he would have expected there to have been.

[109] By way of background, Dr Hearns stated that in relation to a clinical assessment it would be normal practice to undertake three stages of investigation before diagnosis, with these three stages being properly recorded. The first stage in the process would be to take a detailed history from the patient, which would be broken down into symptoms such as pain, including the nature and location of the pain together with other symptoms such as shortness of breath. Details should also be recorded of how long these symptoms had subsisted, and to ascertain whether they had been experienced before and whether the patient had any other illnesses or was taking medication. The witness opined that to obtain a reliable and comprehensive history from a patient who not speak English would be difficult at best and more likely to be impossible.

[110] The second stage would be to consider whether a diagnosis was very obvious having regard to the history obtained, which might make it possible to stop and immediately proceed to treatment, although in most cases this would not happen and the practitioner would move onto stage three. This might be an initial general examination and then a more focussed examination having regard to the disclosed symptoms.

[111] The third stage would involve investigations such as taking vital signs, like pulse, breathing, blood pressure and if required blood glucose. It might also involve matters such as heart tracing. If the described symptoms were indicative of a more

serious illness then further investigations might be necessary. The witness stated that in the absence of stages one and two that any diagnosis would be difficult.

[112] The witness made reference to the PhysicalCare Record recorded by Nurse R during her interaction with Mr Huang on 9 September 2017. On that occasion the witness understood that he had been brought to her by a centre officer and that no translation services were used. The PhysicalCare Record recorded that Mr Huang was "Brought feeling unwell" which Dr Hearns found to be a very non-specific phrase. The witness also expressed concern that this information was passed to the nurse from an officer who could not speak the same language as Mr Huang and that the information did not come directly from Mr Huang himself. Given that the officer did not speak the same language as Mr Huang, the witness was concerned to understand where that information had actually been obtained from.

[113] Dr Hearns stressed the importance of proper communication, and also of maintaining records of observations during the process of assessment. Observations should always be noted when a patient has an encounter with a health care professional. The intention of a medical assessment is to diagnose and either treat the patient or to send them elsewhere for treatment. He stated that it was normal practice for medical staff to make detailed written records of interactions with patients. He would expect these records to include details of presenting symptoms, vital signs, any measurements taken, and findings on examination, diagnosis, treatment plan and confirmation as to whether there was a need for any further assessment. None of this was done in the present instance.

[114] The witness referred specifically to the presentation of Mr Huang at the Healthcare area at 23.30 on 8 September 2017, and noted that there was no record maintained in relation to his symptoms, vital signs or examination, and the information recorded was insufficient to enable a reasonable diagnosis to be made. All that was recorded were the words "cold" and "nasal congestion". Dr Hearns considered this to be inadequate. The references to "cold" and "nasal congestion", appeared to him to be diagnosis rather than symptoms, and certainly the reference to "cold" would fall within that category. He accepted nonetheless that Sudafed and paracetamol might be sufficient for a diagnosis of cold and nasal congestion. He also accepted that if on that date that Mr Huang had simply touched his nose and mimicked a sneeze, and if there was no indication of chest pain, or neck or shoulder pain, and there was no history of heart problems, then that might suffice.

[115] When the patient presented again 2 hours later at 01.20 on 9 September 2017 it was noted that Nurse R did on this occasion take a note of his vital signs. However with regard to his symptoms, all that was recorded was a record of his "Feeling unwell". There were no symptoms recorded and no record of any examination having taken place. There was no diagnosis nor was there any treatment plan recorded. Again this was deemed to be inadequate.

[116] On 18 September 2022 when Mr Huang presented the day before his death, again there was no record of his symptoms, vital signs or examination findings. All that was recorded was "gastric", which was regarded as being inadequate. It was also noted that this consultation took place at a dispensing hatch when he had attended with a fellow

detainee room-mate who had provided interpretation services for them. The witness concluded that it would be difficult to properly assess a patient at a drug dispensing hatch. Whilst acknowledging that he had no experience of working in custodial settings and noting that this may indeed be normal in such establishments, he concluded however that it would be difficult to examine a patient properly in that setting and that if consulting rooms were available that it would undoubtedly be preferable for the patient to be consulted with and examined there for reasons of privacy. The witness also stated that if the full records were available nearby then he would expect these to be accessed, especially for a patient who could not speak English, given that it would be preferable to try and get information about his history etc from this source even if a room-mate was interpreting, enabling the clinician to get as much information as possible. The witness noted that the new policy within the establishment was to ensure that interactions with patients took place in a consulting room and for the patient to get a same day appointment with a GP, practices with which he agreed. The witness also opined that as well as considering the patient's comprehensive history that the nurses concerned should have examined his abdomen and carried out physical observations. His opinion was that they should have carried out a further examination and that it was not sufficient to simply hand out a remedy. He pointed out that "gastric" was not a diagnosis

[117] Dr Hearns concluded that the standard of record keeping on each of the above occasions fell below the standard of any healthcare establishment in which he had ever worked. He stated that the minimum standard of record keeping should have been in

keeping with the Nursing and Midwifery Code on note keeping, which required records to be clear, comprehensive and timely. The notes to which he had been referred did not meet that standard and were lacking in detail as to how the nurses arrived at their diagnoses. The witness also confirmed that he was concerned that Mr Huang had not been thoroughly clinically assessed given that he had presented so regularly to healthcare.

[118] Dr Hearns also stated that having treated significant numbers of patients who had suffered myocardial infarctions he considered that it would be usual for them to be experiencing significant discomfort and for them to appear unwell. He was therefore surprised that Mr Huang had presented to healthcare on a number of occasion, when he was likely to have been suffering from myocardial infarctions, and for him not to have appeared to be significantly unwell. He would have expected the patient to be experiencing pain in their chest and also their back and neck, as well as having a general feeling of being unwell. They might well also have nausea and shortness of breath, as well as feeling anxious due to the stress response. There were likely to be a combination of symptoms and signs, but the patient would generally look unwell, may seem distressed and may well be sweating and pale.

[119] The witness thereafter stated that testing for a myocardial infarction would initially involve undertaking a 12 trace ECG, followed by a blood test and if the troponin levels were unusually high, this would suggest that patient has experienced a myocardial infarction. If Mr Huang had complained of chest pain as reported by Mr Wu, then it would have been necessary for there to have been a full set of vital signs

measurements taken. The witness opined that the nursing staff should also have known that any chest pain in a male of Mr Huang's age who was a smoker mandated a visit to hospital to exclude a cardiac cause of his pain. He believed therefore that if Mr Wu's account of Mr Huang's symptoms was correct that the nursing staff acted inappropriately by not further assessing Mr Huang and sending him to hospital. The witness also stated that if the account of Nurse G as described by Dr Conroy was correct and that Mr Huang complained of "gastric symptoms", "indigestion" or "heartburn" then this in itself would have necessitated a detailed history being obtained from Mr Huang together with his vital signs being measured and an examination carried out. The witness further opined that it would not be uncommon for patients suffering from a myocardial infarction to present with epigastric pain, and that he would have expected that any nurse of doctor would have been aware of this.

[120] The witness addressed the account of Mr Huang, given by way of Mr Wu, to the nurses of chest pain which he indicated by holding his hand to the chest area and using the word "burning". Dr Hearns stated that in these circumstances he would have expected some action to be taken, given that chest pain was a "high tariff" complaint. He accepted that some causes of chest pain could be trivial, but around six causes were serious and potentially life-threatening, and it would have been impossible solely on an account from a patient to exclude these serious possibilities, especially for a male in his 50s who was a smoker. He did also observe that the reference to burning might relate to the oesophagus, and acknowledged that the information patients use to describe pain is not always reliable.

[121] On considering the information which was contained on the KardEx, Dr Hearns opinion was that the person assessing Mr Huang should have obtained further information to exclude the possibility of a previous diagnosis. The fact that there was a previous report of a common cold would not exclude the importance or the significance of the complaint of chest pain. He stated that following a more thorough assessment that the nurse concerned could have made an informed decision as to whether it was safe to prescribe Peptac without a visit to the hospital or whether a hospital assessment was required. In the opinion of the witness a visit to a hospital was likely to have been required, given that an ECG might not reliably exclude a heart attack, and it would need a chest x-ray to confirm the position. Even if the patient was only describing gastric problems or heartburn it would still be necessary for him to be examined by the healthcare experts to exclude more serious causes such as a heart attack. He had observed that Nurses B and G had indicated that Mr Huang had not appeared to be distressed, nor was he sweaty or clammy. In those circumstances, and if apart from placing his hand on his chest there were no other visual signs, then he considered that this might be acceptable and might be possible to produce an effective diagnosis. However where the patient put his hand on his chest, then it would not be possible to exclude a more serious condition, especially for a man in his 50s who was a smoker, and that this would warrant further investigations, given that this was a "high stake" symptom. The term chest pain in itself would mean should be further enquiry. On balance the witness concluded that the standard of assessment carried out by the nurse on 18 September 2017 was inadequate.

[122] The witness also addressed the question of the lack of an interpreter, stating that if the witness had been accompanied to the healthcare area by Mr Wu that this might be sufficient to enable him to communicate to the nursing staff. He did however opine that if there was no interpreter or other detainee present at the attendances of 8 and 9 September, then it would have been impossible for the nurse to adequately assess him. This was significant given the opinion of the witness that Mr Huang was suffering from a myocardial infarction at these times.

[123] Dr Hearns stated further that if Mr Huang had been taken to hospital at any point prior to his cardiac arrest that the chances of him dying would have been significantly reduced, given that hospital treatment for a myocardial infarction would have reduced Mr Huang's chances of suffering a cardiac arrest, and even if he had suffered a cardiac arrest whilst in hospital then his chances of survival would have been greater. Accordingly if he had been referred to hospital the effect on his treatment meant that it is likely that he would have survived, given they have treatments for myocardial infarctions which can break down clots and open arteries thereby restoring the blood supply. If in the event there were difficulties such as the patient's heart not pumping well, again these could be treated. If he was in hospital and known to have suffered a myocardial infarction, he would be placed on a monitor meaning that if it happened again that it would likely be detected and be treatable immediately increasing greatly the patient's chances of survival.

[124] Dr Hearn's opinion was that Mr Huang had suffered two myocardial infarctions whilst he was in Dungavel. He had presented to healthcare staff on a number of

occasions and it is likely that he was experiencing myocardial infarctions on a number of the times he presented to healthcare staff. He also considered that the standard of record keeping maintained by the nursing staff caring for Mr Huang fell below the standard to be expected of professional health care providers, and that the standard of clinical assessment by the nursing staff on 8, 9 and 18 September 2017 was inadequate. The witness also concluded that it was likely that the poor standard of clinical assessment contributed to the failure to appreciate that Mr Huang was seriously unwell.

[125] Dr Hearns confirmed that the objective of any assessment would be to obtain a diagnosis, which will often come down to the professional judgement of the clinician involved. He further acknowledged also that in relation to cardiac arrests that the diagnosis would depend on the experience of the individual clinician.

Witness Thirteen

Dr Karen Hogg

[126] Dr Karen Hogg is a consultant cardiologist working in Glasgow Royal Infirmary with a specialist interest in heart failure and palliative care. Her qualifications are as set out in the Report prepared and lodged in this matter dated 3 May 2021.[44] The witness adopted the terms of this Report in her evidence. This Report had been instructed on behalf of Mr Huang's next of kin and was prepared following a review of the case notes, witness statements, post mortem report and clinical review reports. The witness stated that she had been instructed to establish the circumstances of death, consider whether any interventions would have potentially changed the outcome and to provide an

opinion on what steps (if any) could be considered to prevent other deaths in similar circumstances.

[127] Dr Hogg noted the terms of the post mortem report and observed that the primary cause of death was ischaemic heart disease. It was also noted that Mr Huang had suffered previous myocardial infarctions, and that there was evidence of a healing infarction from about week before and also of a more acute myocardial infarction from approximately 1-2 days before his death. The witness's opinion was that this demonstrated that Mr Huang had experienced heart problems prior to his death, and the post mortem showed that he had severe coronary disease in two of his main arteries. This was evidence of one heart attack two weeks prior to his death and another more acute heart attack two days before his death.

[128] Dr Hogg confirmed that a patient might not always be aware that they were suffering a myocardial infarction. They could present as being very unwell or not, and they could present with very different symptoms. There may be pain other than chest pain and some patients could give differing accounts of pain/discomfort, for example from their stomach or chest which might be difficult to pinpoint. Some patients could also be breathless but experiencing no pain. Others may suffer from jaw pain, given that chest discomfort can radiate to the patient's jaw or ear, and some patients may only refer to this pain without mentioning chest pain.

[129] The witness referred to the question of communicating with patients, stating that this would be critical, especially when it came to diagnosis or considering the need for further investigations for example into chest pain. The witness referred to the

suggestion that on 8 September 2017 that Mr Huang was brought by a member of staff to see a nurse whereupon he had touched his nose and gestured a sneeze in a situation where none of the staff spoke his language and no interpreting services were engaged. The opinion of the witness was that this assessment would not be adequate and that a proper diagnosis in these circumstances would not be possible, given that there could not be any proper communication with the patient.

[130] Dr Hogg also observed that Mr Huang had been prescribed medications for "cold" and "nasal congestion" on 8 September 2017 and that on 18 September 2017 he was prescribed Peptac for indigestion. Mr Huang was therefore treated for a cold/nasal congestion for at least 13 days with paracetamol and de-congestants. The witness opined that this was not normal for a common cold, which should only require treatment for a couple of days and would not necessitate such a prolonged prescription. Whilst during that time a review of the written notes was undertaken by a GP, the witness observed that the poor quality of the medical records would have made it difficult for any GP to make an accurate assessment especially when the patient was not present. The view of the witness was that if a patient presented with cold symptoms for that length of time, she would question why these symptoms were continuing and would wish to have a face-to-face meeting with the patient to enable her to understand the underlying causes.

[131] Dr Hogg also observed that Mr Huang had attended seeking medical assistance on an occasion when the only description of his condition was that he was simply "feeling unwell" was unhelpful. The witness was aware that cardiac events often

occurred in the middle of the night, and an experienced nurse should therefore perhaps have questioned why Mr Huang had wakened so late to seek help. Indeed the very fact that he had been so unwell as to seek help at that time should in itself have been recorded.

[132] The witness noted that on 18 September 2017 that Mr Huang had attended at the Healthcare department complaining of chest pain, at which time Peptac was prescribed under the existing "Homely Remedy" policy for indigestion. It was opined by Dr Hogg that against the recorded background of previous cold symptoms and given the complaint of chest pain with an indication of "burning", that she would have expected Nurse B to have done more to investigate Mr Huang's condition, although she accepted that given the lack of records that it was not possible to clearly see what was discussed and precisely what symptoms were present. If indigestion was properly diagnosed then the dispensation of Peptac might have been reasonable, although looking at the history of eleven days of cold symptoms and the complaint of chest pain, the witness might have expected some further enquiries to have been undertaken.

[133] Dr Hogg also addressed the availability of the 12 trace ECG, which was kept in an adjacent consultation room, and was of the view that this should have been utilised, especially given its ready availability and close proximity. She considered that this procedure would have been standard in the case of someone presenting with chest pains, and that if this 12 trace ECG had been utilised, then it may well have shown that Mr Huang was suffering an acute myocardial infarction. If he had complained of chest pains and there was an abnormal ECG this would have entailed a requirement for a

further assessment, most likely outwith that establishment. It might also have been prudent to have asked for a blood test, to seek further details of his ischaemic history or possibly to transfer him to another hospital for further assessment. Had he been transferred to a hospital then his chances of surviving a heart attack would have been much higher. If his blood test had showed an abnormality, then the witness would again have expected him to be transferred to a hospital setting and therefore his chances of survival would again have been significantly improved.

[134] Having considered the available evidence the witness considered that the written and verbal communications were inadequate in this case, and she also felt able to make three recommendations, namely:

- More detailed documentation should be maintained for each clinical contact
- Automatic triggers should apply for GPs following repeated presentations within a short time or for a continued need for medications over an agreed time period set out at the time of the initial prescription
- Interpreter support should be agreed and documented where English was not the patient's first language.

[135] The witness accepted however also that when Mr Huang's vital signs were recorded on 9 September 2017, that these did not merit clinical concern in isolation, and in particular the relative risk factor for a heart attack was scored at 5.3 which meant that there was a 5.3% chance of heart attack, placing Mr Huang in the low category for such an event. The witness also confirmed that she had not had access to the "Homely

Remedy" policy in force at the time in the establishment, and as such had been unaware that there was no requirement to record further details of medical interactions over and above what was recorded on the KardEx at the relevant time in terms of this policy. In relation to the interaction between Nurse R and Mr Huang on 8 September 2017, the witness further accepted that if there was no indication of any chest pain or pain under arms, neck or teeth, and Mr Huang was not in discomfort, and he only touched his nose and sniffed, then that might suggest a low suspicion of cardiac risk. The witness further accepted that as a cardiologist that she might be more alive to cardiac issues than a general nurse might have been. Again at 01.20 on 9 September 2017 if there had been no indication of any chest pain, or pain under his arms, in his neck, jaw or teeth and he was not in discomfort or sweating, then it might not have been clear that there was anything of a cardiac nature occurring.

Witness Fourteen

Nurse Julie Bowmaker

[136] Nurse Bowmaker is an advanced nurse practitioner, having had a career in health service in a variety of environments including head of health care in a prison setting. The witness had previous experience of reporting on deaths in custody, particularly as a death in custody prison reviewer. Since July 2019 the witness has also been a member of a panel of death in custody clinical reviewers. The witness adopted the terms of her report dated 30 April 2021[45] into her evidence.

[137] Nurse Bowmaker stressed the importance of communication between patients and nurses in allowing the delivery of safe care. She initially noted the position of Nurse R in relation to Mr Huang's initial assessment to be that she had properly used interpreting services. Nurse Bowmaker expressed concern about the situation which would have existed had this not been the case given her prevailing view in relation to communication. As well as adequate communication, the witness confirmed that it was essential that full and accurate records were kept of all patient interactions, the importance of this requirement being reflected in the Nursing and Midwifery Council Code of Practice.[46] The witness confirmed the importance of full and accurate record keeping given that its role in helping clinicians to understand a patient's progress through their health journey. In health care, and especially in a detention setting, these records were an essential means of communication ensuring that all staff knew what had already happened in relation to a patient. In addition she stressed that in any detention centre there should be an equivalence of care with that available outside the establishment and someone in a custodial setting.

[138] Nurse Bowmaker noted that the documentation received from Dungavel suggested that everyone admitted there had the opportunity to see a GP within 1-2 days of their arrival, and in the case of Mr Huang it was noted that he had declined such an appointment. She noted that following this reception stage, that detainees would be assessed by a nurse, whom Nurse Bowmaker believed would require to have access to full and accurate records to enable them to undertake this role. Of great importance was the question of communication, and the witness considered that on the occasions when

Mr Huang interacted with nurses with no interpreter or with his roommate, that this constituted an unsafe practise given that no accurate clinical assessment was possible in the absence of the patient being able to accurately describe their symptoms.

[139] The witness observed that the process of physical or clinical assessment was not limited to observations such as blood pressure, but included what observations that could be seen or heard, such as chest soundings. In this case she believed that Mr Huang had been treated for 11 days by simply being prescribed paracetamol and Sudafed when he had not properly been assessed. There was also nothing in the available documentation to say why Sudafed and paracetamol were prescribed and what might be the cause of any respiratory infection. The witness explained that she would have expected to see a description of exactly what the patient was reporting, recording details such as the existence or otherwise of pain, discomfort, breathlessness, and chest soundings. However she also opined that if there had been a language barrier, then there could have been no safe assessment.

[140] Nurse Bowmaker suggested that it was unusual for an individual to be prescribed paracetamol for a common cold over a period of 11 days, and that this in itself would normally warrant further explanation. She accepted that those observations which had actually been taken by Nurse R could be characterised as unremarkable and would not in themselves give rise to any cause for concern. The reference to "feeling unwell" in the PhysicalCare record was however not a helpful description of symptoms. The witness confirmed that she was aware of variants of the "Homely Remedy" policy across most prisons, and although she had not seen the individual policy for Dungavel,

she accepted that in terms of such a policy that there might be no requirement to make an entry in the physical record policy.

[141] The witness agreed with the suggestion that an absence of a record did not mean an absence of an assessment, although she pointed out that such an occurrence would be in breach of the Nursing and Midwifery Council Code[47] which specifically states that any assessment must be recorded, which would be the case even if an employer had different standards.

[142] In relation to the question of interpreting the witness was referred to the terms of the Detention Services Operating Manual, which stated that it would be acceptable to use other detainees for translation purposes, a prospect with which the witness felt unable to agree, especially in relation to medical matters, and indeed a failure to properly communicate with a patient might in itself amount to a breach of the aforementioned Nursing and Midwifery Code.

Witness Fifteen

Ms Sarah Lynch

[143] Evidence was also led by way of affidavit in respect of the witness Sarah Lynch, who was unwell and unfit to appear in person. She had been employed at Dungavel since 2001, initially as a detention Custody Officer, thereafter progressing to Supervisor, Head of Operations and since 2016 Centre Manager. It was explained that since 2001 there had been five separate organisations contracted to operate Dungavel, and at the relevant time between 2011 and 2021 the relevant operating organisation was Geo

Group UK. Dungavel held a maximum of 125 detainees at any time, the majority of whom were male. These detainees had freedom of movement within the establishment and the witness believed that they were treated well.

[144] Medical facilities were supplied to the establishment by Med-Co who were responsible for ensuring that a similar range and quality of services were supplied as would be available within the community. They were contracted to provide a nurse on site at all times and to have a doctor available on call at all times. The GPs and nurses also ran clinics. GEO Group staff did not have access to medical records given that they were confidential.

[145] Upon arrival at the establishment all detainees progressed to the Admission Room where they were processed.[48] At this stage staff were trained to look for signs of anxiety or vulnerability, and to gauge their responses to questions and evaluate their body language. In the event that the arriving individual was unable to speak English, staff were instructed to use the interpreting service "Big Word" which was available at all times to them. It was explained that the evaluating staff would normally take detainees to a private area where they could converse with the interpreter by telephone. Staff members had a code to enter to access the Big Word service with separate codes being maintained for GEO Group and Med-Co staff. All staff were trained on the availability of this service, and informed that it should be used for important conversations. The costs of this service were met by GEO Group who encouraged its use and as such there was no financial disincentive militating against its use by Med-Co. A consultation room was made available to medical staff approximately seven to eight

feet away from the dispensing hatch and there were telephones giving access to "Big Word" in that consultation room. It was rare that interpreters would not be readily available, especially for Cantonese and Mandarin languages.

[146] After the initial processing stage, the arriving detainees were assessed by a member of the healthcare team who would carry out a medical screening within two hours of the individual's arrival at the establishment. Given that healthcare staff were on site at all times this screening could be done at any time of day or night. Its purpose was to identify any immediate physical and mental health needs of the arriving detainees. A nurse conducted the assessment and the notes of this assessment were to be placed in the individual's medical records. After this had been undertaken the detainee would be moved to the Duke House section of the establishment where they would be monitored for a 24 hour period. Following that first night the detainee underwent a full induction and was handed a "flashcard" identifying their language and advising members of staff of their language requirements in the event that they required interpreting services. At induction the detainees were also advised about the healthcare facilities in the establishment and informed these could be accessed 24 hours a day, and also advised regarding the availability of "Big Word" interpreting services. All detainees were also advised of their entitlement to a GP appointment within 24 hours of their arrival at Dungavel.

[147] The establishment was said to be well appointed, with leisure facilities including a gym and access to a number of educational courses. There were said to be many long-term and experienced members of staff to assist the detainees and the regime was such

that detainees were afforded a degree of freedom and not locked in their rooms at night. There were also telephones in the corridors enabling detainees to contact staff at any time.

[148] It was noted that Mr Huang was scheduled to be moved to Morton Hall in Lincolnshire on 19 September 2017, but on that morning a message was received to the effect that there had been a "code blue" alert meaning that something serious had occurred and that someone had difficulty with their breathing. Emergency services were called but Mr Huang was pronounced dead that morning.

[149] The witness also noted that although the Home Office IS.91 documentation had identified that Mr Huang spoke Cantonese, he would have been specifically asked what language he spoke by the Dungavel staff upon his arrival at the establishment. The information that he spoke Mandarin she believed would have come from Mr Huang via a reception Officer, whereby it would have been added to the Detainee Management System documentation. The witness confirmed that staff at Dungavel cannot accept a person into their establishment without the Home Office IS.91 form, given that this is the legal authority to detain the person and travels with an individual whenever they move through the system. Although the IS.91 recorded the language as Cantonese, the Dungavel staff would have asked the individual this information independently, which means that conflicts can arise between the answers provided. The healthcare staff were however not provided with a copy of the IS.91, given they did not require to see the warrant for detention, and the information on language was provided to them by the Reception Officer. The witness confirmed however that if a nurse required to use an

interpreter and requested the wrong language then the interpreter would advise them that they were unable to communicate with the individual given that it was a three-way conversation. The "Big Word" interpreting service was provided free of charge for Med-Co staff.

[150] It had been noted that Mr Huang's name was erroneously recorded as Gen Blue Wong, which may have been an error in phonetically recording his name. The date of birth of Mr Huang appeared also to have wrongly recorded as being 9 July 1963 given that his son had stated that his actual date of birth was 7 September 1963. The witness was asked on behalf of the family of Mr Huang whether she believed that Mr Huang had been given access to interpreting services given that the nurse has stated that she requested a Mandarin interpreter when Mr Huang did not speak that language, and the witness opined that in that event that the nurse had requested a Mandarin interpreter then the interpreter would have told them that they could not communicate with him. The witness also confirmed that invoices were prepared in relation to the use of interpreters and that the entry for the relevant date and time when Mr Huang was admitted to Dungavel showed no entry on their bill for interpreting services. The witness was further unable to confirm what flashcard, if any, was given to Mr Huang as no records are maintained in relation to their issuing.

Submissions for parties

[151] I heard detailed submissions on behalf of the parties. I have considered these submissions fully. I summarise them as follows.

[152] The Crown's primary submission was to invite the Court to make mandatory formal findings in terms of sections 26(2)(a) and (c) of the 2016 Act to the effect that the death of Xi Biao Huang occurred at 09.22 on 19 September 2017 at Dungavel House Immigration centre, and that the cause of death was ischaemic heart disease. Further the Crown invited the Court make findings under sections 26(2) (e), (f) and (g) of the 2016 Act, and to consider making recommendations under section 26(4) of the 2016 Act.

[153] The Crown submitted that precautions which could reasonably have been taken, were not in fact taken and that this failure to carry out a full and adequate assessment of Mr Huang on 18th September 2017, contributed to the subsequent decision not to carry out any further physical assessments or observations including the taking of vital signs, specifically the failure to use the 12 lead ECG which was nearby and was available for use. Had this been done, the Crown submitted that the chances of Mr Huang dying would have been significantly reduced. The Crown further submitted that the taking of physical observations might reasonably have resulted in Mr Huang's death being avoided. The Crown also submitted that inadequate interpretation services had been used to enable an effective medical examination to be carried out. Any such examination should also have taken place in an available consultation room.

[154] The Crown also submitted that a full and proper assessment of Mr Huang had not been possible due to the poor standard of record keeping and lack of adequate detail within the available medical records.

[155] In addition, the Detention Services Operating Manual relating to interpreters was vague and open to interpretation leading to errors of judgement being made. It also

unduly authorised the use of unqualified individuals to operate as interpreters. In addition the Med-Co "Homely Remedy" policy was not properly recorded giving rise to future difficulties in assessing past medical history.

[156] The Crown also submitted, that there were four other facts relevant to the circumstances of the death, namely:

1. Inadequate assessments undertaken by Nurse R of 8 and 9 September 2017.
2. Insufficient adequate record keeping.
3. Failure to use proper consultation rooms for assessments.
4. A lack of access by nursing staff to the necessary paperwork.

[157] On behalf of the family of Mr Huang it was agreed that in relation to sections 26(2)(a) to (d) that the formal findings in fact as contained with the joint minutes of facts are agreed in relation to the circumstances of Mr Huang's death.

[158] In relation to section 26(2)(e), it was submitted that proper engagement of professional interpreting services from the outset would have allowed Mr Huang to effectively communicate his symptoms to nursing staff. It was also submitted that the available evidence contradicted Nurse R's assertion that "Big Word" interpreting services had been used by Nurse R upon the admission of Mr Huang, and in the event that they had been, that the wrong language interpreter had been engaged. No subsequent interactions between nursing staff and Mr Huang thereafter involved the use of professional interpreters.

[159] It was submitted on behalf of Mr Huang's next of kin that the record keeping within Mr Huang's medical records was inadequate, resulting in a sub-optimal clinical review being undertaken by Dr Ramsey, and allowing the prescribing of paracetamol and Sudafed to continue for a period of eleven days without any proper clinical assessment taking place.

[160] On behalf of GEO Group, who operated and managed Dungavel under contract to the Home Office at the relevant time, it was submitted that there were no reasonable precautions which could have been taken by that organisation whereby Mr Huang's death might realistically have been avoided, and that there were no defects in the organisation's systems of work.

[161] In relation to the question of interpretation services within the centre, it was submitted on behalf of Geo Group that they provided staff, including Med-Co staff, with access to the Big Word interpreting service, which was available for use by staff throughout the centre, and whose existence was familiar to all staff.

[162] On behalf of Med-Co the Court was invited to make mandatory formal findings only. It was also submitted that following the tragic death of Mr Huang that there had been changes to the policies, procedures and systems which they utilised. That they had made improvements did not mean that the standard of care provided to Mr Huang at the time had been poor. However since the date of the death of Mr Huang they had changed the following systems as set out at paragraph 218 below.

[163] It was further submitted that the Minor Ailment or "Homely Remedy" policy, was at the relevant time in line with that which might be operated by a community

pharmacy, and that in any event the nurses employed by them were qualified and experienced and had professional duties and obligations under the Nursing and Midwifery Code which they required to adhere to. It was submitted that Mr Huang was assessed properly, and that none of them had any concerns regarding his presentation when he attended at the pharmacy on 8, 9 and 18 September 2017.

[164] In the course of the submissions made on behalf of the Home Office, reference was made to the Crown criticisms of the Detention Services Operations Manual ("DSOM") as set out in paragraph 19 of the Joint Minute of Agreement in relation to its allowing healthcare team members to make a judgement as to whether an interpreter was necessary and allowing the use of other detainees as interpreters.

[165] The Home Office submitted that this paragraph of the DSOM should not be considered in isolation, given that it was part of an overarching document that provided the framework for all operations at Dungavel, not just the provision of healthcare. It was also said to be a Home Office document, which should not be regarded as being detailed guidance prepared for medical professionals

[166] It was further submitted by the Home Office that the operation of Dungavel was also governed by the Detention Centre Rules 2001 which covered various matters *inter alia* healthcare services. The section of the DSOM which the Crown criticised should be read in the context of the rest of the document, and decisions about the requirement for interpreters, and who those interpreters should be, required to be made on a case-by-case basis. Accordingly if the inability to interpret Mr Huang's symptoms was in any

way causative of his death, it was submitted that that inability was not due to any defect in the drafting of the DSOM.

[167] The Home Office also submitted that the proposed recommendation that all medical assessments be carried out with the use of a professional was unclear in relation to its implementation. The Home Office also submitted that no evidence had been led about the impact of different types of interpreting services or the potential impact of them.

[168] The Home Office further submitted that that the IS.91 form referred to by the Crown, together with the other Home Office paperwork was provided to Geo Group with Mr Huang when he arrived at Dungavel, and that this paperwork recorded his language as Cantonese. It was also submitted that there had been no evidence to suggest that any lack of access to the IS.91 in any way impacted on the treatment provide to Mr Huang or caused his death.

[169] On behalf of Nurse R, whilst making formal findings, I was invited to make no findings in respect of Sections 26(2) (e), (f) and (g). It was submitted that Nurse R had dealt with Mr Huang in an appropriate and professional manner and that there could be no criticism of her interactions with Mr Huang. It was submitted that she had completed the deceased's reception screening assessment on 5 September 2017, and that whilst doing so that she had noted the deceased's language (both reading and spoken) as being Mandarin. In her evidence, Nurse R had confirmed that she completed the reception screening assessment by using the language interpretation service, "Big Word", a position supported by the deceased's son, who gave evidence to the effect that

on occasions an interpreter was available when his father saw medical staff. Given that there were no interpreter services referred to during the interactions on 8, 9 or 18 September 2017 this tended to support the position of Nurse R to the effect that it was during that reception screening assessment that an interpreter was utilised. It was also submitted that as Nurse R could not speak Mandarin, Cantonese or Taishinese, she could only have gained the requisite information contained on the form through the use of an interpreter, as demonstrated by the fact that he had provided positive answers to the questions asked of him, including confirmation that he smoked, that he declined a GP appointment and that he required to see an optician. Accordingly it was submitted that it was not credible to suggest that no interpretation services had been used. It was also submitted that any criticism of the reception screening assessment in terms of the questions asked by Nurse R was misplaced given that she was simply completing the paperwork that she was required to complete as set out by her employer.

[170] In relation to the later interaction between Mr Huang and Nurse R on 8 September 2017 at 2330 hours, when he was prescribed with paracetamol and Sudafed for cold and nasal congestion symptoms, and the lack of any PhysicalCare Record of this meeting , it was submitted that the recording on the KardEx was in accordance with the "Homely Remedy" policy in place at the time of the deceased's death, and as such any criticism of her failure to record this information in that manner was misplaced. Accordingly in terms of her record keeping responsibilities on 8 September 2017, it was submitted that Nurse R had acted fully in accordance with her employer's policy at that time.

[171] In relation to Mr Huang's initial presentation on 8 September 2017, it was submitted that the evidence of Nurse R was clear and consistent to the effect that Mr Huang had simply touched his nose and mimicked a sniff. At no point had he indicated that he was experiencing any pain in his chest, neck, face or teeth. He also did not appear to be in any discomfort in anyway, was not sweating and seemed entirely normal other than touching his nose and mimicking a sniff. Accordingly it was submitted that there would be no reason for Nurse R to suspect that the deceased was suffering from any sort of cardiac issue, and indeed the index of suspicion of the deceased suffering from a cardiac issue during this interaction was so low that there would have been no reasonable precautions which Nurse R ought to have taken at that time other than to take the action which she did.

[172] In relation to the interaction on 9 September 2017 when Mr Huang was brought to her by a staff member complaining of feeling unwell, she had undertaken a number of physical observations, and it was generally accepted that these observations were unremarkable, and that there was nothing from those readings alone that ought to have caused Nurse R any clinical concern. It was accepted that there may have been deficiencies in terms of the record keeping, however Nurse R gave clear and consistent evidence that the deceased had not indicated any pain in his chest, under his arms, in his neck, face or teeth. He was also not in discomfort nor was he sweating. In light of the deceased's presentation, and the unremarkable physical observations, together with her knowledge of his reception screening assessment which had disclosed no prior known cardiac issues, she reasonably had a low index of suspicion in respect of cardiac issues.

It was also submitted that the evidence of Mr Kit Wu to the effect that Mr Huang began complaining of chest pain around two, three or four days after Mr Wu arrived at Dungavel on 12 September 2017 at the earliest, some several days after Mr Huang's interactions with Nurse R on 8 September and 9 September 2017.

[173] In relation to any interactions between the deceased and medical staff after 9 September 2017 it was noted that in relation to the assessment on 18 September 2017, that Nurses B and G had both confirmed that they never accessed the deceased PhysicalCare records when conducting their assessment on 18 September 2017, and as such no reliance was placed by them on those records when they carried out their assessments. These records could not therefore have influenced in any way the decision making of those members of the medical staff. Accordingly whilst there may be some legitimate criticism of these records in terms of the level of detail recorded, there could be no causal link to the deceased's death. In conclusion, insofar as matters related to Nurse R, the court was invited to make no findings.

[174] On behalf of Nurse B it was submitted that she had met with Mr Huang on 18 September 2017 at around 15.00 hours. She undertook general nursing duties as well as a mental health role. She was aware that there were a number of observations which had been made by Nurse R on a previous occasion and were maintained nearby. She referred Mr Huang to a GP the following day, as well as providing him with Peptac in accordance with the establishment's Homely Remedy policy. She had provided evidence to the effect that if she had had any suspicions that Mr Huang had cardiac difficulties that she would have undertaken further observations in the nearby

consulting room and given him aspirin and a GTN spray and requested a blue light ambulance. She had discussed the presentation of Mr Huang with Nurse G whom she considered to be an experienced colleague with considerable experience of working in custodial settings and who had agreed with her assessment. She had taken account of the questions asked and answers received and also the physical demonstrations of Mr Huang.

[175] Reference was made on behalf of Nurse B to the opinion of Dr Conroy and to the terms of his Report, which had stated that: " It is now known that Mr Huang died of the complications of Ischaemic Heart Disease (IHD). There were no preceding symptoms or suggestions of this…. His contact with medical staff seems to have been entirely appropriate throughout. Centre policies were followed and Mr Huang was listed to see a GP on the morning that he died…I am confident that Mr Huang's medical treatment was at the very least equal to that which would be expected in the community. He was dealt with appropriately on the day he first presented with his symptoms and was booked in for the next day to see the GP". This approach in relation to the lack of antecedent symptoms was echoed in the Prison & Probation Ombudsman Report produced which had concluded that: "Mr Huang died of heart disease. He did not present with symptoms indicative of this and healthcare staff could not reasonably have diagnosed this condition. Healthcare staff acted appropriately in line with Dungavel House's healthcare policy." Reference was also made to the terms of the Reports prepared by Dr Hogg and Dr Hearns. Again it was submitted that Nurse B had acted reasonably and professionally at all times

Discussion and determination

[176] Mr Xi Biao Huang was detained on behalf of the Home Office on 31 August 2017 on suspicion of having committed immigration offences. From that date until his death on 19 September 2017 he was detained initially at Campsfield Immigration Removal Centre in St Annes, England, prior to his subsequent transfer to Dungavel on 5 September 2017. He thereafter died on 19 September 2017 within Dungavel. In considering this matter it is helpful to ascertain the journey of Mr Huang throughout this process.

Initial detention

[177] It is a matter of agreement that the deceased Mr Huang was a Chinese national who had moved to the United Kingdom. Notwithstanding the length of his time in the United Kingdom. Mr Huang could not speak English other than to greet or bid farewell to others. He spoke Taishanese, a dialect of Chinese which is related to but distinct from the Cantonese language. He accordingly had some understanding of Cantonese, although he had no understanding of Mandarin. I have noted that the date of birth of Mr Huang appeared to have been recorded as being 9 July 1963, however in the absence of seeing an extract birth certificate, I am prepared to accept the evidence of his son, Mr Zhiming Huang to the effect that his correct date of birth was in fact 7 September 1963, the error perhaps being due to the erroneous utilisation of the American system of date recording.

[178] Mr Huang lived with his son until he was detained on 31 August 2017 in relation to suspected immigration offences, at which point he was immediately taken to Campsfield Immigration Removal Centre in St Annes, England. Whilst in that establishment an initial health assessment ascertained that he appeared to be healthy with the exception of high blood pressure. He reported no serious illnesses or ailments and was receiving no medication. He did not require or seek to see a GP. It was also noted on the Care UK document[49] prepared whilst he was in St Annes at 21.00 on 1 September 2017 that he was physically fit and mentally stable. It was further noted at that time that whilst he had declined to see a GP, he reported as having poor vision and requested that a referral be made for him to see an optician.[50] I consider that it may well have been the case that the information recorded by Nurse R to the effect that Mr Huang required to see an optician was obtained from this document.

[179] At that time documentation was also completed by Home Office officials which was passed to the GEO Group to enable Mr Huang to be transferred. In particular Forms IS.91, IS.91R, IS.91RA and IS.98[51] were completed to be passed to the next receiving establishment, which in this case was Dungavel. This documentation included the warrant to hold Mr Huang in detention. The IS.91 form also contained details of the language spoken by Mr Huang which was recorded as being Cantonese on four separate occasions. It was not however correctly recorded as being Taishanese. None of this documentation referred to Mr Huang as being a Mandarin speaker. The documentation further recorded that Mr Huang had no risks identified, and that he had no medical issues, nor was he taking any medication. It is extremely regrettable and unfortunate

that on none of the occasions when opportunities were presented for accurate details to be obtained from Mr Huang in relation to his first language did it prove possible to ascertain that he spoke Taishanese. The importance of obtaining accurate details of an individual's language for the purpose of interpretation cannot be overstated, and steps should be considered by receiving institutions to ensure that they are able to recognise and accommodate less common languages such as Taishanese.

Arrival and assessment at Dungavel on 5 September 2017

[180] On 5 September 2017 Mr Huang was transferred to Dungavel, and the documentation transmitted with him already prepared by the Home Office as mentioned above was received by GEO Group. Upon his arrival Mr Huang was initially processed by a Detention Custody Officer employed by GEO Group. At his point of arrival Mr Huang was still wrongly named as Mr Gen Bue Wong, with another erroneous date of birth of 9 July 1964 being recorded for him. Accordingly there were clear defects in the documentation provided in relation to the correct details of Mr Huang. I have noted that the errors in relation to the name of Mr Huang may have been caused by the similarity in the phonetic sounds of the name attributed to Mr Huang as well as his correct name, although no direct evidence was presented to the Inquiry as to how this error had occurred. Notwithstanding the fact that the documentation received from the Home Office stated the language of Mr Huang to be Cantonese, the procedure at Dungavel was for the receiving staff to independently check his language with him. This practice clearly facilitated the possibility of differences

arising between the stated and already recorded languages. It is clear that upon his arrival at Dungavel that the language of Mr Huang was recorded as being Mandarin. No officer from GEO Group gave evidence to the Inquiry, which is unfortunate and meant that no evidence was led regarding what was discussed at the induction meeting, and how in the absence of interpreting services any such information had been obtained. In particular it would have been useful to have learned how the recorded information that Mr Huang was a Mandarin speaker was obtained. It is not at all clear on the evidence which member of staff recorded these details, or on what basis the assessment was made that he was a Mandarin speaker. In any event it was clear that this assessment of his language was entirely erroneous, and may subsequently have led to the later difficulties in interpretation. This thread of erroneous documentation and miscommunication appeared to run throughout the detention of Mr Huang.

[181] Following this initial processing by the custody staff, the next stage in the induction process was for Mr Huang to be medically assessed by a member of the healthcare staff operated by Med-Co, the company who operated independently of the NHS and were contracted to provide healthcare facilities to GEO Group. On this occasion the process was undertaken by Nurse R. A Detainee Healthcare Record[52] was completed at 04.30 on 5 September 2017 by Nurse R. This document contained a number of forms, including a "Consent to Treatment" form (erroneously dated as being signed on 5/9/71) and a Reception Screen form. The form is completed in the name of Mr Gen Bue Wong and there is a CID number registered against Mr Huang of 13497621. This number is also registered as a SPIN number for Mr Huang. A further erroneous

date of birth was recorded as being 9 September 1964 for Mr Huang. Again it is not clear where this erroneous information came from. Further the General Practitioner Admission Assessment form was not completed by a GP and was stamped "Declined MO Appt".[53]

[182] At this point there appears to be some doubt as to exactly how this assessment was facilitated. The examining nurse, Nurse R, stated that to enable the consultation to take place she engaged the services of an interpreter from "Big Word". The use of" Big Word" was said to have been commonplace throughout the establishment, this being the interpreting service utilised by GEO Group at that time. The arrangement in place between the parties was that Med-Co staff had free and unlimited access to these interpreting services, and there were no costs to them for using "Big Word" and therefore there could be no financial disincentive for them not to use these services. There were various phones positioned throughout the establishment, including in the medical consulting rooms, with details of how to access the service which could be utilised by detainees and staff members. The process for the use of this service was to have different access codes for the various users, with GEO Group and Med-Co having their own access codes, and thereafter once a language was identified a phone call could be placed to an appropriate speaker of the language spoken, using the different language codes available for each language. Accordingly the call would be placed to an interpreter using the appropriate language code, and once the interpreter was engaged a three way conversation could take place between the detainee, interpreter and the individual engaging with the detainee.

[183] Nurse R was clear in her evidence that she engaged the services of a Mandarin speaker through "Big Word" to facilitate her consultation with Mr Huang. Whilst Nurse R appeared to have been clear in her recollection that she did in fact utilise the appropriate interpreting service, the balance of the independent evidence undermines that position and indeed points against this having taken place. Whilst it may be that Nurse R may genuinely recollect that she had engaged these service, I am unable to accept that her recollection is reliable or accurate in this regard. In the first place it is not possible to understand that a Mandarin interpreter would have been able to engage in a three way conversation with the nurse and Mr Huang as would have been the accepted practice. As pointed out by Ms Sarah Lynch, had a Mandarin interpreter been engaged, it would quickly have become apparent to that interpreter that they were unable to understand and communicate with Mr Huang who could not converse in that language and therefore could not engage with the questions of Nurse B. It is difficult to envisage that a professional interpreter would not be able to recognise that the subject of their interpreting service was speaking an entirely different language, and that they were being asked to interpret a language that was completely unintelligible to the subject. A Mandarin interpreter could not have undertaken this process. Secondly the evidence received from GEO Group following receipt of their invoices from "Big Word", demonstrate that no such services were supplied by them to GEO Group on the date in question, either in relation to Cantonese or Mandarin. This appears to be an accurate and independent indicator of the actual position. In addition there appear to be a number of errors on the form itself, in relation to the date signed as previously

mentioned, and in relation to the fact that it was erroneously recorded that Mr Huang had no next of kin. Accordingly I am not satisfied that interpreting services were in fact engaged at the time of the initial assessment by Nurse R, and in the absence thereof it would not have been possible for there to have been a full and accurate assessment of the condition of Mr Huang upon his arrival at the establishment. Whilst Nurse R did perform a number of physical observations of Mr Huang, and indeed the blood pressure, pulse and other findings were unremarkable, the absence of interpreting services may have led to some confusion as to whether he should have seen a GP upon his arrival (albeit the position adopted by him at Dungavel was consistent with the position adopted by him at Campsfield). This lack of interpreting services, and incorrect recording of Mr Huang's language as being Mandarin may have contributed to later confusion on the part of Mr Huang regarding his ability to access interpreting services in the future. This was extremely unfortunate given the subsequent medical treatment of Mr Huang. Further upon the arrival of Mr Huang at Dungavel he should have been subject to a full and proper medical assessment. To assist in this process the examining practitioner should have been provided with all available documentation received by GEO Group from the Home Office, and in particular the forms IS.91, IS.91R, IS.91RA and IS.98[54] relating to Mr Huang. Had this documentation been supplied it would have been apparent that the most appropriate language of which Mr Huang had an understanding (albeit it was not his first language) was Cantonese, and not Mandarin. Whilst it would have been preferable if the initial assessment of Mr Huang at Campsfield House Immigration Removal Centre had identified that the language

spoken by him was Taishanese, however it was at least apparent that he had some understanding of Cantonese whereas he had none whatsoever of English or Mandarin. In addition the documentation referred to provided some medical history in relation to Mr Huang which might have been of assistance in his subsequent assessments, such as the fact that he was a smoker, which appears not to have been recorded elsewhere. It is apparent that proper interpreting services should have been utilised at the point of the initial assessment. On the basis of the available evidence, and in particular the fact that reference was made to the wrong language of interpreter being utilised and also the fact that there was no record of the interpreting services employed by GEO Group being engaged on the relevant date, I am not satisfied that they were used at the point of initial assessment. Even if they had been employed, they were for a language which was unintelligible to Mr Huang. Had the correct language been identified then the possibility of the future breakdowns in communication might well have been avoided.

{184] The examination of Mr Huang by Nurse R on 5 September 2017 appeared to mirror almost exactly the terms of the medical assessment carried out at Campsfield House on 1 September 2017. No new information was obtained from Nurse R that was not already evidenced on the previous documentation. On 6 September 2017 at 15.00 hours Mr Huang was reviewed by an optician, which was also in line with the information recorded by the Home Office.

[185] From the outset of his stay in Dungavel there were evident communication difficulties for Mr Huang. These appear never to have been resolved throughout his time in Dungavel. The only other time that interpreting services were ever used in

relation to a medical interaction with Mr Huang was when Mr Wu, who actually spoke a different language, assisted him on 18 September 2017. Accordingly between 5 September 2017 and 19 September 2017, between which dates Mr Huang engaged with healthcare services on a significant number of occasions, there were no professional interpreting services utilised. On all but one occasion there was no verbal communication whatsoever between Mr Huang and the medical staff.

[186] Following his admission to Dungavel, Mr Huang kept in regular telephone contact with his son, Mr Zhiming Huang and his daughter in law Ms Miao Dan Li. From the time of his initial detention on 1 September 2017, Mr Huang regularly discussed his health concerns with his family during these regular telephone conversations. He indicated to his family that he was, understandably scared and worried about his current positon, but significantly he also advised them that he was experiencing chest pains. Mr Huang also told his family that he was experiencing other symptoms such as breathlessness, pain underneath his arms and tooth and earache, all of which pointed to an individual who was suffering cardiac problems. This understandably concerned his son, who unfortunately did not know how he could address these concerns on behalf of his father. It was evident therefore from an early stage of his detention, that notwithstanding his apparently normal vital signs that Mr Huang was experiencing cardiac difficulties, a fact borne out by the results of the post mortem which showed evidence of myocardial infarctions during the period of his detention in Dungavel. The evidence of Mr Huang's son and daughter-in-law was corroborated by the evidence of Mr Kit Wu, a fellow detainee who had arrived at

Dungavel a short time after Mr Huang. Mr Wu was a Cantonese speaker, and as such he and Mr Huang were able to converse in that language, meaning they were able to strike up a friendship ultimately sharing a room together. Mr Wu spoke to Mr Huang experiencing chest pain on a regular basis, and observed that he was receiving some medication for this. The evidence of these witnesses was consistent with the outcome of the post-mortem examinations[55] and in particular the evidence of Dr Stephen Hearns[56] to the effect that in the weeks leading up to the date of his death that it is likely that Mr Huang was suffering from a number of myocardial infarctions. It was clear from the available evidence that following his admission to Dungavel that Mr Huang was unwell and that he was experiencing serious cardiac problems. There was however a clear communication difficulty between Mr Huang and the medical staff, which made it likely that he was unable to explain his condition. Had there been no such communication difficulties, Mr Huang would have been able to present his complaints more accurately to the staff which may well have resulted in a timeous diagnosis of cardiac problems. Partly therefore as a result of Mr Huang's inability to communicate with staff, these symptoms evidently remained undiagnosed. Had they been diagnosed properly then, as pointed out by Dr Hearns and Dr Hogg, steps might have been taken which could have prevented the death of Mr Huang.

Assessment on 8 September 2017

[187] It is against the foregoing background of Mr Huang experiencing cardiac difficulties that on 8 September 2017 at around 23.30 that he specifically sought medical

assistance. As indicated by Dr Hearns, it is likely that at that time that Mr Huang may have been suffering from a myocardial infarction and was likely to have been extremely unwell at that time. He was unaccompanied when he sought medical assistance by attending at the health centre. In doing so he was reliant upon the clinical staff to communicate with him in a meaningful manner. When he attended Mr Huang was assessed at the dispensing hatch by Nurse R, which as previously mentioned was simply an adjunct to a corridor leading into a dispensing room. Nurse R stood on one side of the stable type lower door, and interacted with Mr Huang as he sought medical assistance whilst feeling extremely unwell. Given the existing language barrier it is apparent that no other form of verbal communication did or indeed could have taken place. No one else was present at that time, and neither the nurse nor the patient could speak the other's language. Notwithstanding this inability to communicate it did not appear at any time to have occurred to Nurse R that it would be necessary or indeed beneficial to utilise the services of an interpreter from "Big Word". It is surprising that this inability to communicate did not concern Nurse R sufficiently to engage interpreting services, particularly having regard to the communication requirements of the Nursing and Midwifery Code. She was clearly at an advantage over Mr Huang by knowing of the availability and workings of the "Big Word" service, and in the circumstances, particularly given the late hour of his presentation, it might have been reasonable for her to have utilised this service to ensure that she could properly communicate with Mr Huang. Clearly this was not done, and an opportunity to diagnose Mr Huang's underlying condition at a relatively early stage was lost.

[188] The explanation of Nurse R for not engaging interpreting services was that on his initial presentation Mr Huang had simply mimicked a sneeze and held his nose. It was apparent from the evidence of Nurse R that without any form of verbal communication and in the absence of the taking of any vital signs that she had immediately concluded that Mr Huang was suffering from cold symptoms and nasal congestion, and she decided to deal with his condition accordingly. Nurse R thereafter did not maintain a PhysicalCare document upon which she might have recorded the symptoms, results of her examination or diagnosis or treatment plan. Instead, and having concluded that Mr Huang had a cold and nasal congestion, Nurse R decided that she could implement the establishment's "Homely Remedy" policy whereby she could dispense paracetamol and Sudafed. In terms of this policy as it was in operation at that time, this meant that she did not require to record details of her interaction with Mr Huang other than by recording the complaints "Cold" and Nasal Congestion" and indicating that she had prescribed paracetamol and Sudafed on the Approved PRN and PGD Meds document (also referred to and the KardEx). No examination of any kind was undertaken by Nurse R, and no vital signs were taken. His medical notes were not accessed or consulted and the time taken with Mr Huang was very short. A consultation room was nearby but was not utilised by Nurse R. The fact that Mr Huang had sought assistance alone and at such a late hour did not appear to be a particular consideration. Notwithstanding any company policies in relation to record keeping for the prescription of "Homely Remedies", such a lack of record keeping was clearly at odds with the requirement placed upon nurses by the Nursing and Midwifery Code.

[189] Notwithstanding the criticisms made by the representatives of Nurses R and B of the evidence of Drs Hearns and Hogg to the effect that they are consultant doctors and not nurses, and as such might operate to different standards from nurses, I consider their observations in relation to what should have taken place at that time to be persuasive. Doctor Hearns in particular indicated that there should have been a three stage investigative process undertaken when Mr Huang presented seeking assistance. The initial step would have been to take a full history from the patient. This would clearly have necessitated the use of the translation services which were available at all time to the Med-Co staff. As indicated by Ms Lynch for GEO Group, there were no resource implications of the staff of Med-Co in using these facilities. It would appear that there were no other patients seeking assistance at that time, and therefore no reason whatsoever that the nurse could not seek the assistance of interpreting services to enable her to obtain a detailed history from Mr Huang. This would have enabled her to accurately ascertain his symptoms, including the nature and location of any pain and other symptoms such as pain in other areas or shortness of breath. Such a history would also have been assisted by a detailed reference to the medical records of Mr Huang which were stored nearby. As pointed out by Dr Hearns, trying to obtain a reliable and comprehensive history from a patient who does not speak the same language as the clinician would be almost impossible. Had interpreting services been engaged it is entirely likely that Mr Huang might have been able to fully explain all of his symptoms as expressed by him to his son and to Mr Wu. By not accessing the appropriate

interpreting services, a potential opportunity to identify and address the underlying symptoms of Mr Huang was lost.

[190] The next appropriate step would have been to consider whether there was an obvious diagnosis having regard to the symptoms described. Again as pointed out by Dr Hearns, whilst at this stage it may make it possible to stop and immediately proceed to treatment, this would be unusual. In the present case as suggested by the medical evidence a mimicking of a sneeze and pointing to his nose would not appear to be a sufficient basis upon which to base a conclusive diagnosis, especially in the absence of a detailed history as set out above. It would therefore have been appropriate for the nurse to have engaged stage three of the assessment process.

[191] This third stage would have involved further investigations and the taking of vital signs such as pulse, breathing, and blood pressure. None of these steps were in fact undertaken. It was the view of Dr Hearns that the assessment of Nurse R in simply relying on some very basic physical gestures made by Mr Huang was inadequate having regard to the communication barrier, the lack of recourse to existing medical records and significantly the lack of any other investigations being undertaken, and I am in agreement with that assessment.

[192] I also considered the evidence of Nurses Karen Simpson and Julie Bowmaker to be persuasive. They also believed that in order for a proper physical and verbal examination to have been carried out they would have expected an interpreter to have been present. Nurse Simpson also stated that from a nursing perspective, she would have expected a respiratory assessment before any drugs such as Sudafed or

paracetamol were prescribed, and further that there should have been a "head-to-toe" assessment, including the use of a stethoscope to listen for breathing problems. Nurse Simpson also opined that the assessment ought to have taken place in a consultation room, and not in a corridor or at dispensing hatch, and that this interaction should have been properly documented. As indicated, no detailed records were kept of the aforementioned interaction between Mr Huang and Nurse R, and the PhysicalCare Records which should be completed by staff following interactions with patients seeking medical assistance were not completed. It would always be a matter of good practice for one of these records to be maintained and for a detailed record to be kept of the interaction with the patient, given that this would enable detailed information to be available to future treating clinicians. On this occasion the only record kept was maintained on the KardEx, which merely noted the presenting complaint and the medication provided. There was no reference to any symptoms, examination or diagnosis. This was clearly inadequate. Given the comments of Dr Hearns, it is apparent that this was a potential missed opportunity whereby the underlying cardiac symptoms of Mr Huang might have been identified and action taken which might ultimately have resulted in the saving of his life.

Assessments of 9 September 2017

[193] On 9 September 2017 at 01.20, less than two hours since his last attendance seeking medical assistance, Mr Huang was brought to healthcare by an officer of GEO Group, because he was said to have been "feeling unwell". Mr Huang was again seen at

the dispensing hatch by Nurse R and once again no use was made of the available consulting room. No interpreting services were engaged, and Mr Huang was once again unable to communicate with Nurse R and vice versa. On this occasion Nurse R took Mr Huang's blood pressure, and pulse, and his blood saturation and temperature which were recorded on a PhysicalCare form, although there was no record of his symptoms other than that he complained of "feeling unwell". The very vagueness of the phrase "feeling unwell" was understandably criticised by Nurse Simpson as being very subjective, as was the fact that there was no (and indeed could not be due to the language barrier) probing as to what exactly was meant by that phrase. Again no direct information or history came, nor indeed could have come, from Mr Huang himself and there was no record of any examination, symptoms, diagnosis or treatment plan on the PhysicalCare form. Mr Huang could not be communicated with at all on this occasion and accordingly there was no reference to any form of discussion with him. The fact that Mr Huang had attended twice over such a short period of time late at night appears to have caused no particular professional curiosity or concern on the part of the nurse. Whilst Nurse R indicated that the observations taken were unremarkable, and that he did not look particularly unwell, as indicated by Dr Hearns it was likely at this point that Mr Huang was suffering from a myocardial infarction. This fact might have been discovered had interpreting services been used and Mr Huang had had an opportunity to fully and accurately describe his symptoms. Whilst far from detailed on this occasion a PhysicalCare record was at least maintained in relation to this consultation, although

again the terms of the interaction with the patient and the record keeping appear not to have been adequate.

[194] Mr Huang required to attend again with the healthcare team again on 9 September 2017 at 09.10. This was his third presentation within a period of less than ten hours. Given the conclusion of the post mortem report and the evidence of Dr Hearns that it is likely that Mr Huang would have been suffering a myocardial infarction at that time, this further presentation is perhaps not surprising. Once again there is no reference to any interpreting services being utilised by the examining nurse, and as there is no suggestion that anyone else was interpreting for Mr Huang at that time, accordingly there could have been no further verbal communication between Mr Huang and the treating nurses. Again no examination of Mr Huang was carried out by the consulting clinician, and no PhysicalCare Record was maintained of these consultations. The position at that time therefore was that Mr Huang had presented himself for the third occasion within an aforementioned ten hour period with health concerns, and on none of these occasions does it appear was he was given an opportunity through an interpreter to adequately communicate his health concerns. Again no physical observations or vital signs were taken. The presenting complaint was simply recorded as being "common cold" although there is no indication as to how this was ascertained. Once again no adequate records were maintained, constituting another breach of the prevailing Nursing and Midwifery Council Code. Had accurate records been maintained a pattern in respect of Mr Huang's presentations might have been more readily ascertained, and the information recorded may well have guided the treatment

of Mr Huang at the time of any future presentations. Given that it was his third presentation within such a short time Mr Huang's medical records should have been accessed. It would also have been appropriate to have undertaken a proper examination within the adjacent consulting room with an interpreter being utilised. This was a further occasion when an opportunity was missed to ascertain Mr Huang's underlying condition. None of these steps were undertaken and Mr Huang was once again simply prescribed paracetamol and Sudafed. Any future treatment was not specified at that time.

[195] Mr Huang thereafter attended at the healthcare department on 9 September 2017 at 14.35. This was now his fourth presentation within a period of some 14 hours. At this point, again according to the evidence of Dr Hearns, Mr Huang is likely to have had or indeed still be experiencing a myocardial infarction, a fact apparently missed over the course of four separate consultations. Again no interpreting services were utilised and there are no records maintained of any physical observations or examination having been undertaken. The consultation room was not utilised and Mr Huang was again simply seen at the "hatch". It is unlikely or indeed impossible that any proper history or details of symptoms could have been obtained from Mr Huang given that there is no record of any interpreting services having been utilised, and once again no PhysicalCare record was completed, the only record maintained being on the KardEx. This consisted of the complaint "cold" being recorded and paracetamol and Sudafed being dispensed. Again it is difficult to understand how any proper examination or consultation could

have taken place and the standard of record keeping again fell below acceptable standards.

[196] There must therefore be concerns regarding the treatment received by Mr Huang on 8 and 9 September 2017. As outlined above Mr Huang attended seeking medical assistance on four occasions within a relatively short period. It is likely that at least at some point during this time that he was suffering from a myocardial infarction. Notwithstanding the number of visits there appears to have been little done to ascertain the causes of Mr Huang's complaints nor to take steps to diagnose these symptoms and to make a proper diagnosis and develop a treatment plan. Of particular concern is the fact that during none of the aforementioned consultations was there any reference to interpreting services being utilised. It is difficult to envisage a situation where a proper clinical assessment could be carried out when there can be absolutely no verbal communication between the patient and treating clinician. It is also difficult to understand why the services of an interpreter were never used when they were so readily available, especially given Mr Huang attended on multiple occasions during a relatively short period of time. Whilst it is appreciated that Nurse R took some readings and vital signs during the consultation of 9 September 2017 at 01.20 and that these readings were unremarkable, this does not excuse the fact that there were a subsequent two consultations thereafter and no further readings were taken. These failures to take proper observations are compounded by the ongoing failure to adequately record the outcomes of the consultations. The expert evidence in the Inquiry repeatedly emphasised the importance of proper records in mapping the patient's journey through

their treatment plans and guiding the assessments made by future clinicians in their own clinical judgements. It has been a recurring theme throughout the treatment of Mr Huang that there was inadequate recording of the interactions between the healthcare staff and Mr Huang. This failure to adequately maintain records in accordance with the Nursing and Midwifery Council Code was a fundamental basic failing in the treatment of Mr Huang. Of even more concern however is the fact that at no stage during these interactions were there any interpreting services used by the treating clinical staff. I am satisfied that there were adequate facilities available to facilitate the use of these services, and clearly there was no financial disincentive for the staff to do so. This was also clearly contrary to the terms of the DSOM manual[57] in relation to the use of interpreting services. Once again and having regard to the findings of Dr Hearns, a further opportunity to potentially diagnose and treat Mr Huang was lost. As indicated by Dr Hearns, had this opportunity been taken then Mr Huang may well have been afforded appropriate care and taken to hospital at any point prior to his cardiac arrest. Hospital treatment for any myocardial infarction would have reduced Mr Huang's chances of suffering a cardiac arrest, and if he had suffered a cardiac arrest whilst in hospital then his chances of his surviving would have been greater, given that if he was in hospital and known to have suffered a myocardial infarction, he would have been placed on a monitor, ensuring that if it happened again the likelihood is that it would have been be detected and immediately treatable increasing greatly Mr Huang's chances of survival.

Events between 9 September 2017 and 18 September 2017

[197] Between the above dates Mr Huang's medication was considered by Dr William Ramsay in terms of the "Homely Remedy" policy operated by Med-Co. Dr Ramsay was a retired GP who undertook locum duties on a part-time self-employed basis who was, as required, asked to consider Mr Huang's medication on 10 September 2017 in terms of the aforementioned policy. The doctor recalled that on this date that he had been asked by a nurse to continue the medication of Mr Huang. He stated that he considered the available records but did not at any time examine or even consult with Mr Huang. In deciding whether to continue the medication the doctor was entirely reliant on the information that he was supplied with by the nurses given that he was aware that Mr Huang had declined any GP appointments. He completed the prescription chart and prescribed Sudafed for seven days between 10 September 2017 and 17 September 2017 and also paracetamol for thirty seven days between 10 September 2017 and 17 October 2017. Given the lack of medical records which had been maintained in relation to Mr Huang's presentations on 8 and 9 September 2017, it would appear that this prescription was based on very little information. It would clearly have been preferable if the prescribing doctor had examined Mr Huang, particularly given that notwithstanding his initial indication that he had not wished to see a GP that he had subsequently presented on at least four occasions with medical complaints over a relatively short period, when it would also have been apparent that Mr Huang was unable to communicate with the treating nurses. Given the foregoing it might be reasonable to have expected that a consultation or an examination was appropriate,

particularly in light of the paucity of the information contained within the records of his interactions. Had a consultation with a GP been arranged at this time, again the underlying condition of Mr Huang in relation to his cardiac difficulties might have been ascertained. A further opportunity to potentially identify Mr Huang's underlying cardiac condition was again lost.

[198] The recording sheet for prescription (in the erroneous name of Gen Bue Wong) shows that the medication was prescribed on 10, 11, 12, 13, 14, 15, 16, 17 and 18 September 2017. It is noteworthy that the dispensing of Sudafed on 18 September 2017 had continued outwith the terms of the prescription.

Events of 18 September 2017

[199] On 18 September 2017 Mr Huang attended healthcare at 15.00 hours and on this occasion he was accompanied by Mr Wu who was attending with him to act as his interpreter while he sought medical assistance. At this time the nursing personnel on duty at the "hatch" in the healthcare unit were Nurses B and G. They were on duty at the dispensing hatch also dealing with various patient who were attending to have their medications dispensed to them. Mr Huang was initially seen by Nurse B who ultimately enlisted the assistance of Nurse G. The parties are all in agreement that Mr Huang began communicating with Nurse B initially and thereafter with both Nurses B and G through the assistance of Mr Wu. This was an arrangement that was clearly far from ideal. The terms of the DOCM[58] made clear that when engaging with detainees that an interpreter should be used, and that only in the most mundane or run

of the mill interactions should other detainees be used. The use of such detainees was clearly subject to a number of difficulties, particularly given that no guarantees could be given as to the accuracy of the translation provided by these impromptu interpreters. In the present instance Mr Wu spoke a different language from Mr Huang (Cantonese rather than Taishanese) albeit a language which shared certain similarities. It should not have been assumed by Nurses B and G that what was being translated was accurate, especially when accuracy in translation was of such great importance in the context of a medical consultation. Each of the medical experts who gave evidence during the course of the Inquiry stressed the importance of good communication, and explained how a professional interpreting service should be used as a starting point when an individual was attending due to health complaints rather than simply seeking the dispensation of medication. As pointed out by the witness Ms Lynch there were interpreting services available on demand. There was no reason why the nurses should not have accessed the services of "Big Word" to ensure that they were able to properly consult with Mr Huang.

[200] The importance of adequate communication became apparent during the course of the consultation with Mr Huang. The evidence of both nurses was to the effect that they understood Mr Huang to be complaining of a gastric complaint. Nurse B referred to him as having complained of discomfort in his mid-chest area, but indicating that the pain was not sharp and was not radiating. Nurse B had also concluded that he had walked in independently and that he was not breathless or looking unwell. As a result and following a consultation between Nurse B and Nurse G, who effectively provided a

second opinion, they concluded that he was suffering from gastric problems and that he should be prescribed PepTac. An appointment was also scheduled with a GP for the following day at 15.00.

[201] The evidence provided by Mr Wu in evidence was however somewhat at odds with this account. Mr Wu explained that when he and Mr Huang had attended on that date that he had answered a number of question which had been asked by the nurses to the best of his ability, and he specifically remembered advising the nurses that Mr Huang was experiencing chest pain with a burning sensation in that area, and this was said to have been demonstrated by Mr Wu by rubbing his chest. The account given by Mr Wu was consistent with the evidence of a number of witnesses to the effect that Mr Huang had for some time been complaining of chest pain, and was also consistent with the available medical evidence from the post-mortem results confirming that over the preceding two weeks Mr Huang had suffered at least one and more likely two myocardial infarctions. In these circumstances it is difficult to envisage that Mr Huang would have attended at the healthcentre at that time simply complaining of some gastric pain. I am satisfied that Mr Wu undertook his best efforts in attempting to describe symptoms which were indicative of serious cardiac difficulties. The fact that this was not appreciated or understood by Nurses B and G is entirely demonstrative of the deficiencies inherent in using other detainees as interpreters. I am satisfied that if professional interpreting services had been used by the on-duty nurses that Mr Huang would have been able to fully and adequately communicate the symptoms experienced by him, which would clearly have alerted the nurses to the possibility, and indeed

probability that the symptoms experienced by Mr Huang were more indicative of cardiac rather than gastric difficulties. In this regard I have taken cognisance of the findings of Dr Karen Hogg to the effect that the symptoms presented could have been gastric in nature especially in light of the fact that Mr Huang had been assessed as being of a low index of suspicion for a cardiac cause. In the event that this had been the cause of his symptoms, then the appropriate steps were taken for management of that condition and an appropriate GP follow up was arranged for the following day. Given that the index of suspicion was low however the critical aspect of the investigation lay with the clinical history and examination. As pointed out by Dr Hogg, it is common for cardiac pain to present as upper abdominal "gastric" pain and for abdominal pain "gastric pain" to present as chest pain and it can be hard to differentiate clinically. Accordingly an accurate clinical account in the context of the patients' prior history and recent clinical events becomes critical. In the present instance I have noted that for the foregoing reasons that this was not obtained. I have however also noted that going forward that Dungavel has now instituted a system whereby nurses now attend a learning supervision course about differentiating between gastric and cardiac issues. This is to be welcomed.

[202] In reaching the foregoing conclusion I noted the findings of Dr Stephen Conroy that in light of the fact that Mr Huang had no underlying medical concerns, that the diagnosis of vague abdominal/epigastric discomfort appears to have been handled appropriately by the staff at the relevant time and that they dispensed an appropriate remedy and arranged a GP appointment for the following day. In coming to this

conclusion however I have noted that Dr Conroy had observed that Mr Huang had attended at the ”hatch”, and that his room-mate Mr Wu had translated and given a vague history of non-specific sounding abdominal pain. Dr Conroy also observed that “there was no opportunity of any examination at this point as “the hatch” is where medications are dispensed and supervised”. Unfortunately this assessment appears to have been predicated on the basis of two misapprehensions. Firstly, it was the failure on the part of the staff to initiate the procedure for proper interpreting services that has led to the “vague” history being obtained, and I have noted that it would not be proper clinical practise to proceed on the basis of a vague description of symptoms in a situation where there existed a procedure which would be able to clear up this ambiguity. Furthermore no steps were taken to access medical records which might also have assisted in clearing up any “vagueness” about the presenting symptoms. As also pointed out by Dr Hearns it was not sufficient to simply proceed with such a diagnosis without at least taking a full set of vital signs measurements. Further the assessment of Dr Conroy appears to have been based on the erroneous assumption that there was no opportunity for an examination at this point as the “hatch” given that this was where medications were dispensed and supervised. This appears to overlook the fact that whilst this area acted as the point at which medical consultations as well as prescription dispensation took place, that there was an opportunity available to the nurses to undertake an examination in one of the available nearby consultation rooms. Accordingly it cannot be said that there was no opportunity for a proper examination to take place in light of the fact that there were available facilities where this could have

taken place had the treating nurses deemed this to be necessary. That no examination took place in a consultation room was a matter of clinical judgement for the nurses concerned and not due to any lack of facilities. Accordingly and whilst accepting that if Mr Huang had been suffering from indigestion that he had been treated appropriately, the fact remains that the nurses appear not to have been in a position to properly make any such diagnosis in light of the information before them. They did not have a professional interpreter proving accurate information as to the symptoms and history of Mr Huang, and the individual interpreting was not doing so in the first language of Mr Huang, understandably creating a degree of ambiguity about what information was actually provided to the nurses regarding his symptoms. Further there was no recourse to available records to obtain details of his history (such for example as the fact that he was a smoker which may well have had some relevance), and significantly there was no physical examination ever carried out of Mr Huang himself. No vital signs readings were taken and the nurses concerned did not avail themselves of the consultation room with its 12 trace ECG equipment. Given that none of the foregoing was undertaken and that there was such a degree of ambiguity regarding the information provided, it is difficult to see how a proper risk assessment could be carried out at that time. If one accepts the account of Mr Wu to the effect that reference was made to chest pain, together with information regarding Mr Huang's frequent attendances for medical assistance and the fact that he was likely to have previously suffered myocardial infarctions and in all probability was suffering one at the time of his presentation, it is difficult to accept that this was not the account provided to the nurses. If this complaint

of chest pain was not appreciated by them, then this was indicative of the risks inherent in not utilising professional interpreting services in the context of a medical assessment where a patient has presented seeking assistance. If that was the case then this was clearly an inadequate response by the nursing staff. In the event that Mr Wu's account is accepted, which on balance I am prepared to do, then the mere mention of chest pain in relation to a man of Mr Huang's age should have alerted the nursing staff to the requirement to undertake a further assessment, particularly in light of the fact that chest pain is such a high tariff complaint. Whilst appreciating at all times that the exercise of clinical judgement will generally involve an element of risk assessment, it appears to be the case in the present instance that the information which was available to the nursing staff, and which for the foregoing reasons was clearly insufficient, did not allow them to make an appropriate risk assessment in relation to Mr Huang. Had they done so further enquiries would have been undertaken, including a private consultation in the privacy of the consulting rooms as well as the undertaking of a further physical examination of Mr Huang, involving the taking of reading in relation to vital signs and thereafter the use of the available ECG equipment.

[203] In addition to the deficiency in accessing proper and appropriate interpreting services, it is also a matter of concern that the examination of Mr Huang at the time was less than adequate. Mr Huang attended at the dispensing hatch at 15.00 on 18 September 2017. Evidence has been led indicating that this was likely to have been a busy time whereby many other detainees would have been attending seeking medication. Whilst appreciating the stresses involved in allotting time to competing

patients' interests, the time taken for this particular consultation has been estimated as having lasted approximately five minutes. As mentioned by Dr Hearns there was a three-stage investigative process which should have been undertaken at this point , including obtaining a full history with details taken of symptoms, the length of their subsistence, and whether the patient suffered from any other illnesses and taking medication. In the present instance this would have been very difficult, if not impossible, to undertake within five minutes given the inherent deficiencies in the interpreting services utilised. There should have been a general examination leading to a full investigation including the taking of vital signs. This latter step would have been particularly important given that no such vital signs had been taken from Mr Huang for at least nine days.

[204] Further it was clear that any such investigation should have taken place within a private consultation room. The Inquiry heard evidence there were such rooms readily available, however these were never accessed by the nurses at any time in relation to any of Mr Huang's attendances. Given that there should have been a physical examination of Mr Huang, this should clearly have taken place within the privacy of the available consultation room. This would also have given access to items such as the 12 trace ECG device which would have been invaluable in assessing the condition of Mr Huang.

[205] It was also regrettable that the medical records of Mr Huang were not fully accessed at the time of the consultation. Again these records were stored in a location extremely close to where the nurses interacted with Mr Huang and Mr Wu. An examination of these records would have disclosed that Mr Huang had been

experiencing medical difficulties for a period of ten days which may have further identified the requirement for further investigations. This was particularly important given that there were such inherent difficulties in obtaining a detailed history from Mr Huang given the problems of translation.

[206] It is also once again concerning that no adequate records were maintained of this consultation with Mr Huang. No PhysicalCare form was raised and the only record of the interaction with Mr Huang was to the effect that he presented with a complaint of "Gastric" and he was prescribed Peptac, a "Homely Remedy" utilised for such ailments. It is apparent that there should have been a proper medical record maintained of the details of the presenting complaint, the symptoms, and diagnosis and treatment plan.

[207] As assessed by Dr Hearns and Dr Hogg had Mr Huang been referred to hospital following his attendance on 18 September 2017 then this would potentially have increased his chances of survival from the event . As suggested by Dr Hearns had Mr Huang been taken to hospital at any point prior to his cardiac arrest then the chances of him dying might have been significantly reduced. Hospital treatment for a myocardial infarction would have reduced Mr Huang's chances of suffering a cardiac arrest, and if he had suffered a cardiac arrest in hospital then his chances of surviving this would have been greater.

The use of "the Hatch"

[208] It became obvious during the course of the Inquiry that a principal cause of concern was the multi-faceted use of "the hatch". This area was effectively a door onto a corridor served as a dispensing point for medication to be provided to patients. Evidence was led that this was an extremely busy facility with up to 200 patients a day attending to seek medication. This was however also the principal "gateway" point for patients seeking medical attention. It became apparent that Mr Huang required to seek medical assistance on a number of occasions, and that as a result his method of accessing healthcare was to attend at the "hatch". There were treatment and consultation rooms adjacent to this facility, however it also became apparent that these were not always used for the purpose of assessing patients, and that, as in the case of Mr Huang consultations would often simply take place at the "hatch". This was clearly an unacceptable practice. Apart from the fact that no privacy or confidentiality could be afforded to patients, it also meant that physical assessments and vital signs readings were seldom taken. It is significant that in the case of Mr Huang that vital signs were only taken from him on one of his five presenting occasions. It appears to have been the case that this practice militated against physical examinations taking place which clearly impacted upon the quality of the clinical assessments being undertaken. It is difficult to conclude that the consultations which took place at the hatch could have been adequate in the absence of private discussions and examinations taking place. I have noted that since the death of Mr Huang that Dungavel have improved a number of their policies. In particular any patient who now attends at the hatch with a presenting complaint will

be seen separately from those being dispensed medications and a consultation will be booked, and that this policy will apply when patients drop into healthcare, when appointments will be provided and they will be seen in a consultation room. Further I have noted that the layout of the pharmacy has changed and there is now a separate and distinct medication hatch from which medication is dispensed. These changes are to be welcomed, but for the avoidance of doubt there it should be made clear that the dispensing and consulting facilities are entirely separate. Patients who require to seek medical attention should not be required to attend at the dispensing hatch. The medical consulting and pharmaceutical aspects of the healthcare systems should be entirely separate, and there should be no overlap between them. Separate booking systems should be maintained for each aspect of the medical healthcare. It is also the case that going forward all medical consultations should take place in a private consultation room. There should be absolutely no question of any such consultations taking place in corridors or at "hatches" again in future.

Assessment of the treatment of Mr Huang

[209] In assessing the treatment provided to Mr Huang by the nursing staff I have paid particular attention to the submissions made on their behalf to the effect that they should not be judged against the standards of the medical staff, but rather by the standards of nursing staff. In this regard I have noted the terms of the report prepared by Julie Bowmaker, a registered General Nurse who presented her qualifications as a Nursing Expert Witness in a range of hospital and community settings, as well as having

experience of acting as a custody clinical reviewer. I have also taken cognisance of the evidence of Nurse Karen Simpson, a consultant nurse with experience of being a Heath Care Manager within a custodial setting. Both witnesses were accordingly well qualified to comment on the standard of nursing care received by Mr Huang during his time at Dungavel.

[210] Ms Bowmaker referred to the initial assessment of Mr Huang upon his arrival at Dungavel on 5 September 2017, commenting that this assessment lacked details, and that whilst a number of boxes were ticked that there was no free text to give an overall picture of Mr Huang's health or presentation. The difficulties with translation were also highlighted by Ms Bowmaker. Nurse Simpson also highlighted the fact that there was no room on the form to clarify the condition of the patient on arrival and would also have expected that there would be some recorded evidence in relation to the use of the interpreter at the relevant time

[211] In relation to the assessment of 8 September 2017 and thereafter, Ms Bowmaker observed that Mr Huang was treated by way of "Homely Remedy" for a URTI (Upper Respiratory Tract Infection) for an eleven day period when he was not examined or seen by a GP. As pointed out by Ms Bowmaker, one would have expected over that period that there have been some assessment of his presentation including a history of coughs, breathlessness, sputum haemoptysis or any other respiratory symptoms. Further it would have been reasonable for there to have been a respiratory examination, and at the very least that physiological observations be carried out and recorded such as respiration rate, temperature, pulse, blood pressure and capillary refill time as well as

measurement of oxygen levels. Nurse Simpson would also have expected that a respiratory assessment would have been carried out prior to the prescription of drugs such as Sudafed and paracetamol, including a chest sounding to listen for breathing problems. Again the witness concluded that in the absence of an interpreter to facilitate the asking of questions that this would have been an unsafe assessment. Further both witnesses agreed that there was a lack of adequate recording of the patient interaction.

[212] On 9 September 2017 Mr Huang had attended at an early time (01.20) with a presenting complaint of "feeling unwell". It was observed that this was an extremely vague and subjective complaint, which was never clarified. As noted there were no clinical observations, no descriptions of the nature of the illness, and no detailed assessment, diagnosis or management plan. In the absence of an interpreter it is difficult to understand how an accurate assessment could have been carried out at this time, and this failure would have been in breach of the requirement contained within the Nursing and Midwifery Council Code that nurses must take reasonable steps to meet people's language and communication needs. In the present instance no steps were undertaken to address these needs. This was particularly unfortunate given the findings of Dr Stephen Hearns to the effect that it was likely that Mr Huang was suffering from a myocardial infarction when he attended at the Healthcare area between 23.30 on 8 September 2017 and 01.20 on 9 September 2017. Once again both Nurses Bowmaker and Simpson concluded that there had been inadequate recording of the consultation, again in breach of the Nursing and Midwifery Code.

[213] In relation to the consultation of 18 September 2017, Ms Bowmaker has noted that all that was recorded was "gastric" and again that there was no description of the patient's presentation, or of his symptoms and also that no clinical observations were taken. Ms Bowmaker referenced the fact that Mr Wu had acted as an impromptu interpreter, although this led to ambiguity and doubt about what symptoms were actually described by him. It was noted that the relevant nursing staff did not confirm how they had arrived at their diagnosis of gastric symptoms, and as pointed out, given that patients with myocardial symptoms often described their symptoms as being heartburn/epigastric pain, that a more detailed assessment should have taken place including as a minimum, physiological observations being taken including respiration rate, temperature, pulse, blood pressure and capillary refill time and oxygen levels taken. The opinion of Ms Bowmaker was that this failure was not reasonable or adequate and that no professional person of ordinary skill would have taken that course of action if acting with ordinary care. This was echoed by Nurse Simpson who observed that she would have probed the complaint of "gastric" further, especially if there was reference to burning in the chest area, and that there should have been a further assessment to exclude any cardiac red flags. Again she would have used a stethoscope to take chest soundings. Nurse Simpson would also have expected there to have been further investigation into an increase in Mr Huang's systolic blood pressure as well as an increase in his pulse especially given the presenting complaint of chest pain.

[214] Nurses Bowmaker and Simpson were also in agreement that the standard of record keeping undertaken by the nursing staff on each occasion did not comply with

the terms of the Nursing and Midwifery Council Code which clearly states that nurses must keep clear and accurate records relevant to their practice. In this regard the records of the individual nurses treating Mr Huang fell below the acceptable standards required by the aforementioned Code. Whilst accepting that the individual workplaces might have less stringent rules in relation to record keeping, such work place practices do not exempt treating nurses deviating from their own professional standards.

[215] In relation to the use of interpreting services, again the conclusion of both Nurses Bowmaker and Simpson was that the failure to utilise professional interpreting services at any time throughout his multiple attendances for medical assistance was not a course of action that a professional person of ordinary skill would have undertaken. The difficulties in using fellow detainees, especially those who do not speak the same language as the patients have been outlined above. Regrettably this appears to have been the case in this instance.

[216] Much of what has been outlined above might understandably be taken as being somewhat critical of the standard of nursing care afforded to Mr Huang whilst he was resident at Dungavel. Whilst this is not my intention, having regard to my findings this is perhaps unavoidable. However it should not be taken as being individually critical of the nurses who attended to Mr Huang on each of the occasions that he sought assistance. It is accepted by me that these individuals work in stressful conditions and that they are all working under great pressure. I am grateful to all of those who assisted the Inquiry in its function. The findings imply no criticism of any individual. The Inquiry has had a considerable advantage over those involved at the time. It has had the

benefit of hindsight and the opportunity to review in slow motion, and in detail, circumstances and decisions which faced busy professionals working in real time and, often, with only part of the overall picture. The recommendations made here are not intended to add to that burden; quite the opposite. Taken together, if implemented, they should support those working within detention centres in their duty to safeguard the wellbeing of detainees. They should make it easier to identify and address risk thereby relieving the inevitable distress caused when unforeseen risks materialise with tragic consequences. Most of all, however, it is hoped that the recommendations will avoid other deaths in circumstances similar to those of Mr Huang. Regrettably however there were a number of systemic problems inherent within the Dungavel establishment, which were exacerbated by individual clinical decisions which I have highlighted. I am also heartened to note that since the tragic death of Mr Huang that a number of changes have been introduced to deal with a number of these issues by Med-Co as follows:

- Medical notes are now annotated to record when an initial homely remedy is prescribed. This allows Med-Co to monitor recurrent presentations for the same minor ailments and escalate the same to a GP.
- Additional training around documentation has been rolled out to staff.
- They complete an e-learning annual documentation course.
- A new computerised patient management system has been introduced called Vision has been installed by NHS Lanarkshire.
- Any patient who comes to the hatch during medication round will be seen separately, a consultation will be booked.

- This will also apply during the day when patients drop into Healthcare. Appointments will be provided or, they will be seen in a consultation room.
- The layout of the pharmacy at Dungavel has changed in the intervening period. There is now a medication hatch from which medication is dispensed.
- There are consultation rooms on either side of the hatch into which detainees are taken if a consultation is required.
- Previously all staff attended annual Basic Life Support (BLS) training. This has been replaced with Intermediate Life Support training.
- Nurses attended a learning supervision course about differentiating between gastric and cardiac issues.

[217] These changes are to be welcomed and should be read in conjunction with the recommendations made above.

[218] Once again I wish to convey my deepest condolences to the family and friends, some of whom attended the Inquiry with great dignity, of Mr Xi Biao Huang in relation to their loss.

APPENDIX A

IN THE SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

JOINT MINUTE OF AGREEMENT

between the participants in causa

FATAL ACCIDENT INQUIRY

into the Death of

XI BIAO HUANG, born 9 July 1963

The Procurator Fiscal Depute for the Crown, Ms Connelly, Counsel for the next of kin, Ms Toner, Counsel for GEO Group UK Ltd., Ms Fraser, Counsel for Med-Co Secure Healthcare Services Limited, Mr Mulgrew, Solicitor for Nurse B, Mr Burton, Solicitor for Nurse R, Ms Harris, Solicitor for Nurse M, Ms Thomson, Solicitor for the Home Office do hereby concur in stating to the Court that the following facts have been agreed and can be admitted into evidence.

1. On 31 August 2017 Xi Biao Huang was detained by Immigration Officers in Bootle, Merseyside on suspicion of immigration offences. He was initially detained within Campsfield House Immigration Removal Centre, Kidlington.

2. Mr Huang was medically assessed on 1 September 2017 at Campsfield House where it was noted that his blood pressure was high, but his pulse was normal. No

other medical issues were raised or noted at this time. It is recorded that he declined a consultation with a GP.

3. On 5 September 2017, Mr Huang was transferred to Dungavel House Immigration Removal Centre, Strathaven where he continued to be detained on the authority _of the Home Office. He was located at room 1, Hamilton House within Dungavel House Immigration Removal Centre.

4. Dungavel House Immigration Removal Centre was operated by GEO Group UK Ltd. ("Geo Group") under a contract between the Home Office and Geo Group, when Mr Huang was detained there in September 2017. The Detention Services Operating Manual and Detention Centre Rules 2001 governed the operation of Immigration Removal Centres including Dungavel House Immigration Removal Centre in 2017. Production number 1 for the Home Office is the Detention Services Operating Manual.

5. Med-Co Secure Healthcare Services Limited ("Med-Co") were a subcontractor of Geo Group. Med-Co were subcontracted by Geo Group to provide healthcare services at Dungavel House Immigration Removal Centre in 2017.

6. Mitie Care and Custody Ltd. has operated Dungavel House Immigration Removal Centre since September 2021.

7. Medical centre staff at Dungavel House Immigration Removal Centre are employed by Med-Co Secure Healthcare Services Ltd.

8. It is stated in the Detention Services Operating Manual relating to health care arrangements in place at Immigration Removal Centres that "the Centre must ensure that appropriate decisions are made about the use of interpreters or translated materials

on a case by case basis. The level of communication must be adequate to ensure correct clinical outcomes" (section 13, page 36, Production number 1 for the Home Office).

9. Mr Huang's name was recorded as Gen Bue Wong upon being taken into custody. Mr Huang was a Chinese national. When he was taken into custody by the Home Office on 31 August 2017, Mr Huang was served with forms IS91R, 1S98, and IS98A by Home Office staff at the time of being detained. Production 6 for the Home Office is the form IS91R, Production 8 for the Home Office is the form 1S98 and Production 9 for the Home Office is the form 1598A. It was recorded on the IS91R and the 1598 documents that the contents of these documents were explained to Mr Huang in Cantonese.

10. When Mr Huang arrived at Dungavel House Immigration Removal Centre on 5 September 2017, hard copy forms IS91RA and !591 were handed over to Geo Group by the Home Office Escorting Contractor. This is as required on page 10 of the Detention Services Operating Standards Manual. It is recorded on the 1591 document that Mr Huang spoke Cantonese. Production number 5 for the Home Office is a copy of the form 1S91.

11. On his arrival at Dungavel his first and only language was recorded in the Dungavel records as Mandarin by the Dungavel GEO staff. In the GEO Group Discharge Report, which forms Crown Production 14, his first and only language is recorded as Mandarin.

12. Mr Huang received a medical assessment upon his arrival at Dungavel House Immigration Removal Centre on 5 September 2017 at 0430 hours. The assessment was

carried out by nurse R. It was recorded by nurse R that she had used "Big Word" translation service. Records produced by "Big Word" do not record "Big Word" interpreter services for mandarin or Cantonese being engaged during this consultation. It is recorded that Mr Huang declined a consultation with a GP. Mr Huang was noted to have no medical issues. He was referred to an optician. His blood pressure was recorded as 127/84.

13. Mr Huang made a medical complaint in Hamilton House at 2330 hours on 8 September 2017. He was seen by nurse R and was prescribed Paracetamol and Sudafed for a cold and nasal congestion.

14. Mr Huang made a further medical complaint at 0120 hours on 9 September 2017. He was escorted to the Healthcare centre by a Detainee Custody Officer ("DCO"). He was again seen by Nurse R.

15. On 10 September 2017, Dr William Ramsey (a General Practitioner) reviewed medical notes and prescribed Mr Huang Paracetamol and Sudafed. This followed Med-Co's policy in place at the time in terms of which permitted nurses to prescribe "homely remedies" for a period up to 3 days only. Thereafter a doctor is required to prescribe any medication.

16. Dr William Ramsey was a locum GP sub-contracted by Med-Co. He is now retired. In September 2017 he was a self-employed contractor.

17. A "homely remedy" is an over-the-counter medication for minor ailments. Paracetamol, Sudafed, Peptac and Gaviscon are "homely remedies".

18. Mr Huang made a further medical complaint at 1500 hours on 18 September 2017 and was assessed by nurse B. Mr Huang was prescribed 10 ml of Peptac as a homely remedy. Nurse B communicated with Mr Huang using his roommate Mr Kit Wu as an interpreter.

19. The Detention Services Operating Manual relating to Interpreters/Translations states, "It is acceptable for the Centre to use other detainees, visitors or staff to interpret for other detainees, provided that both parties agree." The Manual further states, "With regard to medical matters it must be for the doctor or other healthcare team member to take a view on whether an interpreter is necessary. Other detainees or members of staff may also assist if the detainee is content with such an arrangement.

20. At around 0825 on 19 September 2017, Mr Huang was found in bed by his roommate, Mr Wu, who upon checking him, found he was unresponsive. Using the telephone in the hallway outside the room, Mr Wu alerted Detainee Custody Officer Jacqueline Brown who alerted Detainee Custody Officer Alex Raeside.

21. Detainee Custody Officer Alex Raeside attended room 1, Hamilton House and found Mr Huang in bed. He was found to be unresponsive. His forehead was cold to the touch and his lips and fingertips were beginning to turn blue. His neck, chest and arms were warm. DCO Raeside raised an emergency code blue alarm and commenced CPR. DCO Raeside was joined by DCO Majid Nazir.

22. A code blue alarm is an emergency medical assistance call used when someone is not breathing. A 999 call was made and paramedics in East Kilbride received

instructions to attend at Dungavel House Immigration Removal Centre at around 0831 hours.

23. Nurses G and M attended immediately and found Mr Huang to still have some warmth in his body. Nurse G noted Mr Huang as having no pulse and that he was unresponsive. He commenced CPR and use of defibrillator on Mr Huang. This indicated that Mr Huang was asystolic.

24. Around 0853 hours paramedics Lorna Weir, Colin Mitchell and Susan Ferguson arrived and took over CPR. Paramedics also performed an ultrasound after attempting various treatments. Life was pronounced extinct at 0922 hours on 19 September 2017.

25. Mr Huang was conveyed to the Queen Elizabeth University Hospital where a Postmortem examination was carried out on 26 September 2017. The cause of death was given as 1a) Ischaemic Heart Disease. Crown Productions 2, 3 and 4 are copies of the Postmortem Report, Toxicology Report and Supplementary Postmortem report respectively. The information contained therein forms part of the evidence to which regard may be had in determining the issues in this inquiry.

26. In September 2017, the medical assessment of new residents at Dungavel House Immigration Removal Centre was done on a paper form.

27. The healthcare team at Dungavel House Immigration Removal Centre now use a patient management system called Vision. This is the system operated by NHS Lanarkshire. It was not in place in September 2017. At that time the healthcare team utilised paper medical notes.

28. The healthcare team at Dungavel House Immigration Removal Centre require to request medical notes from prisons (if applicable) and the resident's GP practice using the resident's name, date of birth and a signed mandate from the resident. The procedure in this respect was the same in September 2017.

29. The healthcare team at Dungavel House Immigration Removal Centre have access to a live telephone translation service procured by the centre operator. In September 2017 the service was Big Word procured by GEO Group. Recently, they have had access to Language Line. Currently they have access to Big Word procured by Mitie.

30. Med-Co has a matrix of mandatory training which all nurses are required to undertake and update as necessary. In September 2017 all nursing staff received annual face to face basic life support training. They now receive immediate life support training which is a higher level.

31. Med-Co undertake audits of medical notes and prescriptions.

32. In 2017, audits of medical notes were undertaken by Med-Co bi-monthly of five sets of medical notes and five prescriptions for three clinicians. Now monthly audits are undertaken of five sets of medical notes and five sets of prescriptions for three clinicians.

33. That Production 9 on the Inventory of Productions for Geo Group UK Limited is an affidavit of Sarah Lynch, Centre Manager at Dungavel, sworn on 13 July 2022, and should be treated as her parole evidence.

34. Crown Production 5 is a copy of the NHS Clinical Review in respect of Mr Huang's death

35. Crown Production 6 is a copy of the Prison and Probation Ombudsman's investigation into the death of Mr Huang.

36. Crown Production 11 is a copy of the Home Office Immigration Detainee Movement Notification file relating to Mr Huang.

37. Crown Production 12 is a copy of Mr Huang's Med-Co detainee medical records.

38. Production 1 for Med-Co is a copy of the Minor Ailment policy as reviewed on 11 August 2020.

39. Production 2 for Med-Co is a copy of the Minor Ailment Policy due for review on 5 July 2019.

40. Production 3 for Med-Co is a copy of the protocol for paracetamol.

41. Production 4 for Med-Co is a copy of the protocol for Sudafed.

42. Production 5 for Med-Co is a copy of the protocol for Peptac/Gaviscon.

43. Production 6 for Med-Co is a copy of the Medical Records Protocol as reviewed on 12 June 2020.

44. Production 7 for Med-Co is a copy of the Medical Records Protocol with a review date of 13 June 2018.

45. Production 8 for Med-Co is a copy of the Resuscitation Policy as reviewed on 26 July 2021.

46. Production 9 for Med-Co is a copy of the Minor Ailment Policy updated on 22 July 2022.

47. Production 10 for Med-Co is a copy of the Medical Records Protocol updated on 15 July 2022.

48. Production 11 for Med-Co is a copy of the Accessibility and Translation Policy dated 11 July 2022.

49. Production 12 for Med-Co is a copy of the Healthcare Services Audit Template.

50. Production 1 for the Next of Kin is a Report by Dr Karen Hogg, Consultant Cardiologist dated 3rd May 2021.

51. Production 2 for the Next of Kin is a Report by Ms Julie Bowmaker, RGN BSC(Hons) dated 30th April 2021.

52. Production 3 for the Next of Kin is a copy Invoice no. INV579905 dated 30th September 2017, from "the bigword" to GEO Group UK Limited, Dungavel House IRC, Strathaven, relating to the period 1st September 2017 9.54 am to September 30th 2017 at 3.49pm.

53. That Production 10 on the Inventory of Productions for Geo Group UK Limited is a supplementary statement taken from Sarah Lynch, dated 4 September 2022, and should be treated as her parole evidence.

IN RESPECT WHEREOF

Procurator Fiscal Depute.,
Counsel for Geo Group UK Limited
Counsel for Med-Co Secure Healthcare Services Limited
Solicitor for B
Solicitor for R
Solicitor for M
Solicitor for the Home Office

[1] Crown Production 3 Post Mortem report of Dr John Williams dated 6 November 2017

[2] Productions 4-8 of the List of Productions for the Secretary of State for the Home Department

[3] Production One for the Secretary of State for the Home Department "Detention Services Operating Standards Manual for Immigration Service Removal Centres" issued January 2005 Page 45 paragraph 4

[4] Production Two for Med-Co Secure healthcare Services "Med-co Minor Ailment Policy-Dungavel" Review Due 5 July 2019

[5] Production One for the Secretary of State for the Home Department page 45

[6] Nursing and Midwifery Council "Professional Standards of Practice and Behaviour for Nurses and Midwifes Code" 2015 Page 9

[7] Production One for the Secretary of State for the Home Department "Detention Services Operating Standards Manual for Immigration Service Removal Centres" page 36

[8] Production 4 for the Secretary of State for the Home Department

[9] Production 5 for the Secretary of State for the Home Department

[10] Production 6 for the Secretary of State for the Home Department

[11] Production 7 for the Secretary of State for the Home Department

[12] Production 8 for the Secretary of State for the Home Department

[13] Crown Production Twelve

[14] Production two for Med-Co Secure Healthcare Service "Med-Co SHS Dungavel Minor Ailment Policy"

[15] Crown Production Twelve

[16] Crown Production Twelve

[17] Crown Production Twelve

[18] ibid

[19] Production One for the Secretary of State for the Home Department

[20] Crown Production Eleven

[21] Crown Production Twelve

[22] Crown Production Twelve

[23] Production Two for the Secretary of State for the Home Department

[24] Production Three for the Secretary of State for the Home Department

[25] Production Four for the Secretary of State for the Home Department

[26] Production Five for the Secretary of State for the Home Department

[27] Crown Production Twelve

[28] Crown Production Twelve

[29] Crown Production Twelve

[30] Crown Production Twelve

[31] Crown Production Twelve

[32] Production Number One for Next of Kin

[33] Production One for the Secretary of State for the Home Department page 36 paragraph 13

[34] Ibid page 45 paragraph 4

[35] Ibid page 45 paragraph 6

[36] Crown Production Eight

[37] Production two for Nurse B

[38] Crown Production Five.

[39] Crown Production Ten.

[40] Crown Production Seven

[41] Crown Production Twelve

[42] Nursing and Midwifery Council Record Keeping Guidance for nurses and midwives (2009) Page One

[43] Crown Production Eight

[44] Production One for the Family of the Deceased Xi Biao Huang

[45] Production Two for the Family of the Deceased Xi Biao Huang

[46] Nursing and Midwifery Council Code 2015

[47] Nursing and Midwifery Code 2015

[48] Crown Production Twelve

[49] Crown Production Twelve

[50] Crown Production Twelve

[51] Productions four to eight for the Secretary of State for the Home Department

[52] Crown Production Twelve

[53] ibid

[54] Productions 4-8 of the List of Productions for the Secretary of State for the Home Department

[55] Crown Production Three

[56] Crown Production Eight

[57] Production One for the Secretary of State for the Home Department page 36 paragraph 13

[58] Production Number One for the Secretary of State for the Home Department