Investigation into the attempted suicide of Mr [redacted] D[redacted] at Pentonville Prison on 27 December 2001

Date of Interview:	**11 July 2006**
Name of Interviewer/s:	**Ali McMurray, Prisons and Probation Ombudsman's Office**
Name of Interviewee:	**Shirley Boateng**
Also Present:	**Stephen Shaw, Prisons and Probation Ombudsman**

Female:	Today is Tuesday 11 July 2006 and the time is just gone five past ten. Present in the room is Stephen Shaw, Shirley Boateng and Ali McMurray. Stephen Shaw, the Prisons and Probation Ombudsman, is carrying out an investigation into the circumstances surrounding the attempted suicide of Mr [redacted] D[redacted] at Pentonville Prison on 27 December 2001. I am assisting him. Shirley would you confirm that you have received a copy of the letter inviting you for interview, the Notice of Investigation and the Notes for Interviewees and that you have had an opportunity to read them?
Shirley Boateng:	Yes I have received it.
Ali McMurray:	Thank you and would you please confirm that you understand that the Ombudsman's report will be disclosed in due course to the people the Ombudsman decides are relevant and that the transcript of your interview may be attached to the report?
Shirley Boateng:	Yes.
Ali McMurray:	Thank you. And would you please confirm that you understand that you may be accompanied by a work colleague or a trade union representative during this interview?
Shirley Boateng:	Yes
Ali McMurray:	And do you want a work colleague or trade union representative present with you?
Shirley Boateng:	No

Ali McMurray:	Okay. Finally, would you please confirm that you understand that if during the course of the interview you wish to have a break for any reason you may do so.
Shirley Boateng:	Yes I do
Ali McMurray:	Okay, thanks for that. Moving on to the meat of the interview then, as I said I would like to start by asking some questions about what healthcare was like back in 2001. Now I understand that back then the healthcare was actually on R wing. Can you describe what it was like physically?
Shirley Boateng:	R wing is an extension of one of the wings leading on from C wing. There were, on our wing there were five floors. There was the basement which was H1, dating to the hospital, there was H2 which we had patients as well, R3 was the administration bit of it and R4 was where we had other patients at times when there was an overflow. R5 was where vulnerable prisoners were housed.
Ali McMurray:	Right, so not actually, not healthcare patients just ordinary VPs?
Shirley Boateng:	Yes. Healthcare patients were R1 and R2.
Ali McMurray:	Right, and as a wing what was it like? I mean was it clean and bright and tidy?
Shirley Boateng:	Well it was fairly clean, there were, it is an old building, the structure was old but at the time it was made the best of, you know, the inmates, patients who were well enough, like the cleaners they would paint and on occasions to brighten it, there was some of them who were very good artists. Today the paintings still exist down there, excellent paintings, country scenes, aquariums and things, very good artistic works, still exists there today, you know to brighten it up, keep it lively and so on. There were cleaners who cleaned it, swept, mopped every day under supervision and I guess that on occasions they did paint it up when it was grim, you know the paintings, dirty, that sort of thing.
Ali McMurray:	And what were the cells themselves like?
Shirley Boateng:	I am not quite good with measurements but they were fairly small, housed, each one housed the single ones had a bed, a table and chair and a locker in which they could put their

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clothes, there was a sink and toilet in there which was partitioned off, sort of partitioned off. Those that were occupied by two people or who had the occupancy for two people had double bunks, two lockers, one table, two chairs, you know which they used, toilet and ...

Ali McMurray: Okay, and what did, how did it feel? Like a healthcare centre or did it feel just like a wing in a prison?

Shirley Boateng: Well, it was a wing, you can't get away from that. It was a wing in a prison, you know, the physical structure looked like it, but we tried to make it as healthcare based as possible. For instance, there was on landing 2, there was the nursing station in the middle of it, down on the ground floor, H1 there was the Wendy house, what we called the Wendy house, observation point, you know where you can see both ends. There was the treatment room with equipment, nursing the clinical rooms and so on. Those things you would not find on the ordinary landings. We had the treatment rooms like I said and other things that related to nursing that was not on the wings.

Ali McMurray: And the fact that it wasn't originally designed for healthcare, how did that affect the way that it worked and your care of the patients?

Shirley Boateng: I didn't mention on the 2 landing there was a five bedded bay, a short of Florence Nightingale type bay with curtains, and there was an office there which was, you can see all your patients, you know, from that point of view observations was like in a hospital in a Florence Nightingale ward, the only thing about that it was partitioned off the ... where the office was ... the nurses office that was glass, not glass but plastic ... that was the ... and you had observation too to the shower room, you know, that you can see there if someone is having a shower and you can, and that needs to be observed, you could do that. So from a nursing point of view the observation there was quite good. Apart from that the other part of the 2's landing where the nursing station was, the cells that were directly opposite on both sides you had good views but on the other sides there ... to be observing anybody you had to be physically in front of there. They all had flaps, what we call flaps that you can see through, you can observe, you can physically put your hand through it if necessary but there were five cells which were for patients or inmates with tuberculosis those had glass in order to get

in, that had to be opened, the door physically had to be opened, you can see inside but if you had to get in, or to give medication on that side you had to open the door physically, so those were the cells that were used for isolation, if you can understand that. Down on the 1's they were pretty much the same as the others, you know, those directly opposite the Wendy house on either side you have access, you know, to view there but those for the time on either side you would have to go there to be observing. If there was any patient that was on, you know, one to one observations, we had high chairs that the staff can sit on and then your eyes would be at level of what is going on inside, you know, you can see ...

Ali McMurray: ... right, you so you keep the cell door closed?

Shirley Boateng: ... yes if the person is ...

(SPEAKING TOGETHER)

Shirley Boateng: ... depending on the temperament of the person if they were very aggressive and things like that of course you wouldn't leave the door open but you had a view to what is going on in there, so that if you see anything going on and you need to get in immediately there would be no obstruction, and then there were staff, officers and staff around, so help was readily available.

Ali McMurray: And what was the point of the constant watches, just to watch the prisoner, keep him out of harm's way or were staff also required to engage with them and to keep them in conversation? How did that work?

Shirley Boateng: Those on constant watch would be, there would be access, you know, there wouldn't be the glass to block them off, you could talk with them even if the door is closed. Sometimes they come out and sit down, you know, like I said depending upon on their mood, how aggressive they were and things like that. They would sit outside and you would chat with them, you know they could look at the television and things like that. Or on occasions we went in there, we would sit in the room and chat with them, assessing their mental state, you know their moods, getting information and things like that, so like I said that depended very much on the inmate's level.

Ali McMurray: And did you find that you had enough time to do that, to spend time actually sitting with them?

Shirley Boateng: On a one to one?

Ali McMurray: Yea

Shirley Boateng: Yes, even with that person once you were allocated to that person you constantly was with that person.

Ali McMurray: That is all you do the whole shift?

Shirley Boateng: Yes except when you are relieved for meals or for a short break, you know, bathroom.

Ali McMurray: And in terms, assuming, I mean some of the patients would have been mentally ill were they, as opposed to physically ill?

Shirley Boateng: Yes

Ali McMurray: What sort of environment was it for somebody who is mentally ill? Was it the sort of environment you would hope to have mentally ill patients in or ...?

Shirley Boateng: Well there is a difference, a distinct difference between the two, the two being hospital, where you would have the mentally ill patient and the facilities that go with it and the prison environment, bearing in mind the prison environment was based more on custody. Efforts to have a therapeutic environment were made, there were games in which you can engage the person, there were RMN's Registered Mental Nurses, as primary nurses, who would be able to assess, to formulate the care plans ...

Ali McMurray: ... and were they actually on the staff or were they ..?

Shirley Boateng: yes on the staff, there was primary nurses, for instance at the time I was a Staff Nurse, I was a primary nurse and I was employed by the prison. There are also agency nurses who are RMN who have come in on a sessional basis, day to day, two days, and so on. Efforts were made for continuity of care, so you find that if a nurse is in to do a one to one today and that same nurse is coming back tomorrow for continuity, you know, that would be made and of course if

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there was a case where the nurse wouldn't be there again, well then someone else would have to take over.

Ali McMurray: Right, and that was all in place four years ago as well, was it?

Shirley Boateng: Yes when I was a Staff Nurse, yea. Of course it is much more improved now, we have better facilities, more modern facilities, we have the hospital wards and there is more space, like I said there is more modern facilities, i.e. each patient has got a television in their room, they smash them up ... you know that was in the beginning, we have the personnel officer and primary nurse scheme or named nurse, which they both work together, you know, communicate to meet the needs of the patient. We have got, at the time, we did have the yard but ... on that side but here it is more like, although it is a yard, it has got grass which gives it a different feel, you know and I mean observing the patients going out there now, they would sit on the bench, they would, some of them pick flowers and even bring up, you know you can tell that they have a better ... how shall I say ... they pay more attention to their environment now than they did then. In those days when they were down in the yard it was quite noticeable that they would go down to the exercise yard and they would either sit on the wall, chatting or they will go round, you know, in a sort of institutional fashion, walk around or run around. Now that doesn't happen. You see them, they will do their exercises and they sit and chat, you know, things like that. There is better facilities now like, for instance, now they have got, they take out like orange juice, you know make it a more .. so they have things to drink and you know, it is more homely, now than it was then.

Ali McMurray: Right, and what sort of regime was in operation four years ago in healthcare? Were prisoners out of their cells for most of the day or hardly any of the day or ...?

Shirley Boateng Well it varied according to how they presented If they were very aggressive and on three staff unlock they would not be out on the landing with the other inmates because of the risk involved, so you find then that they would be, those with three man unlock would be out on association on a separate time, being supervised by those officers, they would like come out, have their baths, have showers, if they want to make phone calls, they do, watch the television, they would

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be out there on individual basis or probably sometimes two of them if there were two and the officers there to supervise them, the other inmates would be behind their doors. Those who well then there was a choice, some of them would say they don't want to be out and they would be left in with their doors open, we leave the doors open and the other would be out usually from about nine they would be about from nine, ten in the morning, they go in, they collect their meals and then they go back in and after lunch around two o'clock, they go out for exercise in the exercise yard. When they come back they would stay out on the landings until supper time they get their meals and then they are locked away. By about half five, six o'clock you know to facilitate the roll correct, you know, count them and things like that.

Ali McMurray: So long as the prisoner wasn't likely to be a problem, then they would spend quite a lot of time at least with their door open ...?

Shirley Boateng: With their door open and some of them had activities that they go to, you know, education classes and things like that.

Ali McMurray: Was that actually provided on the healthcare wing or did they go somewhere else in the prison?

Shirley Boateng: Those who were alert, and of no risk to anybody, used to go to the education classes out on D wing and C wing. They had different classes, but those who were a bit unstable but needed stimulation and so on, there were tutors who came and spent like two hours, you know, limited period at each of them. Sometimes there were those who the exams to do or tasks, the teachers came up with their allocated work, gave them the ... explain whatever and leave them to do their work and then they would come back to collect it. Now in the healthcare some go down to the day hospital, those that are well they go down and they occupied in the day hospital where they have different things like, they do art, they have relaxation sessions, they have got things like psychological, neurological testing and things like that in the day hospital. They can engage in those sort of things, and those who remain upstairs, the patients, they are out from about half eight. They have their cleaning and cleaners in their rooms, and they are supervised doing that by the staff and after that they stay out. If there is someone who is on a three man unlock or so, they would stay in and come out, like when the others, they have a period of time where they are outside

and then they will bring those out one by one. Their cleaning is supervised, their showers they are allowed a period of time and then they go back in.

Ali McMurray: Right, there again going back to 2001, what sort of place was healthcare to work? I mean was it organised? Was it efficient? You know, was there a sense that everybody knew what they were doing, where everything was? How was it?

Shirley Boateng: The regular staff, yes, knew where everything was, staff the permanent staff knew where things are, regular staff and the agencies who would come in, they knew where things were because they were there on a regular basis and they were part of the team. It was an environment where, yes we got on quite well as a team, support was readily available. That is one thing that manifested itself on various occasions, training ...

Ali McMurray: .. support from Managers or just from colleagues ...?

Shirley Boateng: From your colleagues, you know, I suppose if you needed support of management it was there but it was more readily with your colleagues. Training for staff was not, it was a bit lapsed, there was not that amount of opportunities for training on a regular basis although having said that there were spasmodic times when you know there was training like, there were a couple of nurses who went on to do their degrees and things like that. Study days and so on, when I first came on a Thursday afternoon, the prison would be, on what you call, patrol state and that was used for training. So there were training of different types, you would go over to Heaken House which was, still exists for training, and you would have different aspects of training there. In healthcare itself we had training like you know, we had a specific officer who did CPR, cardiac pulmonary resuscitation skills, for the afternoon, we had outside people coming in on occasions doing things like manual lifting, the courses on that, you know. Although it was not on a grand scale but we did have it on occasions.

Ali McMurray: What training did you have in suicide prevention?

Shirley Boateng: Suicide prevention those who used to go on it at Heaken House, I think it was one thing that was quite frequent. It used to be on like every week, every other week, there

would be a course and staff were encouraged to go on the suicide prevention course, you don't always get to go because of the level of staffing but suicide prevention ...

Ali McMurray: ... so people couldn't be spared off the wing?

Shirley Boateng: Well according to the level of staffing that there was, you know, one staff would go at a time or possibly two. But it was there, the course was there suicide prevention.

Ali McMurray: Did you do it?

Shirley Boateng: Yes I did.

Ali McMurray: And what ...

Shirley Boateng: ... On two occasions.

Ali McMurray: And what was it actually about, what did it teach you do?

Shirley Boateng: How to identify prisoners, patients who were at risk, you know. How to assess their moods and so on, and how to conduct a risk assessment and encourage reporting to the relevant person, when someone on a one to one what to look for, and so on and how to complete the necessary documentation, you know that sort of thing. It was a fairly good course. I haven't been on it for a few years but I would think it is the same. Now what they have got updated is the ACCT which is much more intense than the 2052SH was, so I would say that the suicide prevention course now is much better than it was before. It is more detailed, you know, both in theory and in documentation and so on, it was more ... it is much more easily understandable.

Ali McMurray: Right and you have done that training or you haven't done that training?

Shirley Boateng: Yes I have done it, I am also one of the assessors.

Ali McMurray: Oh right, okay, and the training you had back in 2001 on the 2052SH, was that adequate? I mean did you feel confident that you knew what you were doing?

Shirley Boateng: Well I did because I doubly qualified, I am an RMN as well, so it is my line. So yes I feel comfortable.

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Ali McMurray: Right and your colleagues, they felt comfortable?

Shirley Boateng: As far as I know. If one was not, you know if someone was new to it, it was explained and I haven't heard anyone complain to say that they did not understand it, although it is much more simple and detailed now but then I don't know if anyone complained to say they didn't understand what it was about.

Ali McMurray: Because it is quite intimidating dealing with people who might harm themselves, isn't it?

Shirley Boateng: It is because you can't get into somebody's mind. Unless you are engaging with that person, you know you wouldn't realise what they are planning, what they are thinking, sometimes you talk with them and some patients are very good at putting on a façade, so you know you ... they would be talking and laughing and the next minute they have self harmed, they could conceal the weapons, things like razors which they would ask, you know, "Miss can I have a razor?" and if one, you know one is not vigilant to examine that razor when it gets back to you, they can easily take the blade out of that and hand it to you and you don't know that they have done that. Some of them are very clever, they would ask you for a razor and they will ask someone else, so when they hand you back that razor the other person's, the other one they had from someone is still in their possession, you know, so you have to have sort of eyes behind your back even in that way you still couldn't be 100% vigilant with them. Back to the question of self harming, you have the 2052, your observations we had what we call handovers, you know that information would be passed on from one to another - what Mr X was like yesterday, and what he is likely to do, you know, what are the things to look for and there was the opportunity to ask questions and things like that. I thought that we had a fairly good team and a fair amount of skills among the team so detecting if someone is at risk of self harm, of course we didn't always get it right, sometimes even though the information was passed on, we still have that today, although to a lesser degree, you know, that some people don't really keep that intense vigil or pay particular attention to information that was passed on, you know, sometimes on hindsight you think well yes this was said, or that was said, had I paid more attention, you know that sort of thing on hindsight, but in my experience, you know, I think there were the skills of the staff, still save many lives.

Ali McMurray: That was going to be something I was going to ask you. What was the level of self harm or potential self harm on the healthcare centre at the time? What proportion of inmates would have been considered to be at risk?

Shirley Boateng: Well apart, well I think anyone of those who came in were considered to be at risk, some more so that others. The mentally ill patients they are at risk at any time because they are not thinking straight, especially if their illness is one that involved hallucinations, things like that and they are prone to being obedient to their voices, they can self harm very easily, those who suffer from paranoia they are at risk as well, and there were some who would self harm just to prove a point. When I say to prove a point, if they don't get want they want, you know they will self harm, they are very impulsive people, so the mentally ill ones they were the high risk of self harm having said that, we had ... those who were known self harmers and then ... well they either come in to healthcare because they have self harmed or they are threatening self harm or there are some who would self harm, but most of them were those who had self harmed before, you know the first time ones .. so in all I would say probably about, I would say about a third or probably 45% clientele within healthcare that had been proved to some form of self harm, either hanging, taking overdoses, hiding their medication, you know, or laceration, things like that.

Ali McMurray: And what range of measures did you have to hand to care for people that were likely to self harm?

Shirley Boateng: Well we have assessment process, that is one. We had primary nurse system where the nurse would know ... get to know you to build up your relationship with your patient and get to know when something didn't seem right or sometimes they themselves ... the patients themselves they will threaten, so we would have that, some of them would be behaving in a funny, you know their behaviour would give them away.

Ali McMurray: If you were drawing up a care plan for somebody what might you put into the care plan?

Shirley Boateng: I would take into consideration the person's history, if they have a previous history of self harm that would be one, their state of mind at present time, would be another factor to take

into consideration whether that person is having hallucinations, you know, that sort of thing. By listening and observing you know, you can ... they might be talking to someone else, you know you overhear conversations between them. Probably they might be hoarding things like (inaudible) a razor.

Ali McMurray: You had different levels of watches?

Shirley Boateng: Different level of watches for different people. Every inmate was on a half hourly watch

Ali McMurray: Regardless of ...?

Shirley Boateng: Regardless everyone has a ... watch, we go round and you check half hour, to know where every inmate is. That is one thing, the half hourly observation sheet where you have to sign to say that is done and that is (Inaudible), you have to know the patients who are off or the inmates who are off the landing or presently on the ward you have to know that they are ... we have boards with running totals, what we call running totals, so if an inmate or patient has left the ward and goes, say to visits, you put the name of the person who is a visit, whether they need a visit or social visit, as they come back you delete the name from the board and you have a total, running total so at any one time you know how many on the ward, off the ward and where they are, you know.

Ali McMurray: And the special watches, who would determine the level of special watches were?

Shirley Boateng: If the person is on one to one, usually the doctor because before you put an inmate on one to one he is seen by a doctor ...

Ali McMurray: ... always ..?

Shirley Boateng: Yes, the doctor says what level, well you know, whether they are on one to one or 15 minutes or half hour, if I, as a Charge Nurse, one of the junior managers and I am not comfortable with the inmate's presentation and I think he needs a more increased observation than half hourly but not as a one to one, I can put him on a 15 minute watch. I would inform the other staff and so on, so every 15 minutes that person is seen, his whereabouts known and it is

documented on a sheet, a 15 minute watch sheet, and it is signed.

Ali McMurray: And is that regularly each 15 minutes or do you vary it a little bit?

Shirley Boateng: Every 15 minutes that person is seen. Now you find that he would be seen most likely like every five or ten minutes because you are walking around, you know, but you don't, you have to sign that sheet to say that every fifteen minutes he is seen and you know where he is and you know what he is doing and you document what that person is doing as well. So we have those three levels of observations, the one to one or constant watch, the 15 minutes or half hourly, but everybody has got a half hourly.

Ali McMurray: The semi furnished cell, when would that be used?

Shirley Boateng: If a prisoner is very aggressive, they are smashing things and so on, things that they can use as potential weapons or potential self harming things are taken away, you know taken out of the cell until that person has calmed down.

Ali McMurray: So tend to be used more for dangerous inmates than for ..?

Shirley Boateng: .. but that is in their own room we do not have ...

Ali McMurray: ... take furniture out?

Shirley Boateng: Yea, you just take the furniture out You know that is another improvement from old hospital. If someone was behaving badly you would move him out of his normal cell and he would go in the special cells where, as you call it, the unfurnished cells where there was just a bed and in some cases the locker if you know he was not deemed to smash that locker and use it as a weapon. But now they remain in their cells all we do is take away, like the television, you know, or take out the locker or anything that he would use to self harm ...

Ali McMurray: ....Just going to halt you there a minute, I am going to change this tape because I am not happy with the noises it is making ...

PAUSE

SIDE 2

Ali McMurray: ... tape changed, thanks very much ...

Shirley Boateng: Another thing regarding observation which we did as another improvement on healthcare we have computers which you can see into every cell, you know ...

Ali McMurray: ... oh right, what, here now or this is before?

Shirley Boateng: Yea, no now. It is in the office, you know there is a little room where it is all the gadgets whatever and in the office there is a computer screen in which you can see into every cell. You can see the inmates in their cell, you know, so you have that also for observation as well.

Ali McMurray: Right. The semi furnished cell that you used to use - when you actually put an inmate into a designated cell, what was that actually like physically, can you just describe the room?

Shirley Boateng: It was just cell with ... ordinary cell really, there was one that ... iron bars but it was an ordinary cell where you can put a bunk, same size as ordinary cell with a bunk but it had no extra furnishings.

Ali McMurray: Right, so what made it semi furnished as opposed to unfurnished, what ...?

Shirley Boateng: ... well there was no locker, like I said, there wasn't a chair, just a bed and toilet facilities.

Ali McMurray: And any bedding?

Shirley Boateng: Yes there was, there were two one with the bed, the other one, there was another one that if the person (HIGH PITCH NOISE) was likely to hang themselves or had a history of that they had the .. they would put the mattress on the ground, you know, because they can tilt the bed easily.

Ali McMurray: And was there any limit of time as to how long somebody could be kept in the cell?

Shirley Boateng: They would be reviewed every two hours, they used to be reviewed and seen by the doctor and the ... when they come, you know, interaction and negotiation when they would come out.

Ali McMurray: So it was very much a short term measure?

Shirley Boateng: As little time as possible they spent there.

Ali McMurray: Okay, thank you.

Shirley Boateng: Having said that I know there was probably was one or two people who spent like a night, day and night because of their behaviour.

Ali McMurray: Because they were likely to harm themselves or because they were likely to do damage to someone else?

Shirley Boateng: To other people, both.

Ali McMurray: Okay, thank you. Case conferences on people thought to be at risk of suicide. Who was responsible for co-ordinating them and for drawing up support plans?

Shirley Boateng: There was the multi disciplinary team. Case conferences used to be held on a weekly basis, I think it was every Wednesday, and it was a multi disciplinary decision. There was the doctor, the nurse and officer, social worker, psychologist, there were visiting Consultants from the forensic team, you know they were used to be a very a multi disciplinary ...

Ali McMurray: ... and did the prisoner himself take part?

Shirley Boateng: No, not when, I say no. They would interview the patient in order to get their details but at the conference the patients did not necessarily go in to them. One or two of them went in but not all of them.

Ali McMurray: And how were the decisions of the case conferences communicated to staff on the landings?

Shirley Boateng: We had handovers in the morning after every case conference, we would have a handover. The information was filtered through ... (HIGH PITCH NOISE) ... them anyway.

Ali McMurray: So the notes from the case conferences were made available to everyone?

Shirley Boateng: Oh yes.

Ali McMurray: And you were confident that that was all working quite well, you felt that people were communicating well?

Shirley Boateng: In general, overall fairly good I wouldn't say it was of the best but it was fairly good.

(A HIGH PITCHED NOISE IN THE BACKGROUND KEEPS GOING)

Ali McMurray: And in what ways did it fall short of being the best?

Shirley Boateng: I worked in a forensic psychiatric unit before and the communication there was ... if not A1 I would say (HIGH PITCH NOISE)... in ways that it fell short was that we didn't have as many meetings as we did then, because you know the more interaction, the more meetings, the more information and it will be ... more readily. Here it didn't have that (HIGH PITCH NOISE) much interaction.

Ali McMurray: ... you mentioned forensic psychologists and psychiatrists, how often did they visit? Was provision adequate for the needs of the healthcare at the time?

Shirley Boateng: Yes, I think so. We had forensic consultants from the North London forensic area, the East London forensic area, Islington forensic area, there was a lot of input, you know, coming to see ... because once the patients, whatever, catchment area they are from their relevant consultants were informed and they visited, did their assessments, formulated reports and they still do come now, well there are more of them now, I suppose because forensic has grown, you know, there are more doctors to look after them. They have very good input and from general psychiatry as well.

Ali McMurray: Right and the systems of referrals back in 2001, did that work quite smoothly, was everybody seen fairly quickly?

Shirley Boateng: Yea it could be dependent upon what you mean by that. Two or three weeks (HIGH PITCH NOISE)

Ali McMurray: ... and would you say that is good enough?

Shirley Boateng: Sometimes people needed to be seen on a much more urgent basis.

Ali McMurray:	And was there separate system for urgent cases ... a way of fast tracking people through or did they just have to wait their turn in the queue?
Shirley Boateng:	Well no, there were some that were seen not urgent, urgent basis, you know, if for instance ... give an example, someone came in from court, the courts played a very great part in that, if someone is mentally ill and they have got a request from the court for report, a psychiatric report or a forensic report and he has got to go to court in a week or two, that person will be seen much quicker than someone else, so, yes ... and of course there are some individuals much more efficient that others.
Ali McMurray:	Okay, I think those are all the general questions I wanted to ask. If I may, I will just run this incident report by you and see if you ... (HIGH PITCH NOISE) ... I am not sure if it is written by you or if you are just making a comment. I am just going to stop the tape for a moment.

(PAUSE)

(HIGH PITCH NOISE)

Ali McMurray:	Shirley has just taken a few moments to read through ...do you remember anything of that particular incident?
Shirley Boateng:	Yea vaguely
Ali McMurray:	Do you remember Mr D[redacted] at all?
Shirley Boateng:	No, I cannot put a face to the name at all. But I ..
Ali McMurray:	Do you remember the incident .. (HIGH PITCH NOISE) talk a little bit around it ...can you remember, for example, how bad the cuts were?
Shirley Boateng:	No.
Ali McMurray:	If you can't that is fine - as I say I wouldn't want you to make it up.
Shirley Boateng:	No, I can't remember how ... I don't think he had sutures, I don't think it ... I can't remember if he had sutures or just steristrips or what sort of dressing ...

Ali McMurray: ... and you can't remember anything about him?

Shirley Boateng: .. have you got any of the details, you said the IMR's are missing.

Ali McMurray: Yea, everything is missing unfortunately.

Shirley Boateng: Because this would have had a documentation in his IMR as to exactly what was done.

Ali McMurray: You can't remember how he presented at the time - whether he was angry, whether he was very tearful or anything like that?

Shirley Boateng: No, I cannot remember this chap at all.

Ali McMurray: Okay, it is four and a half years ago, so ... well I think that is all the questions I have for you Shirley, thank you very much. Stephen have you any?

Stephen Shaw: I just have one question Shirley, how often did the governing Governor come and visit healthcare?

Shirley Boateng: Governing Governor we had was Governor Davies. I can't remember but Governors usually, they would come around to healthcare about once or twice a week sometimes, sometimes not for the week, it would depend, because I mean, they could come down and I don't see them, you know, I mean I work four days a week there, three of the days which they can come, but (HIGH PITCH NOISE) ...

Stephen Shaw: ... let me put it to you this way, in the time that Governor Davies was the governing Governor how often did you see him?

Shirley Boateng: Oh see him in healthcare, how often?

Stephen Shaw: Hmmm

Shirley Boateng: About once a week, once a week, once a fortnight, he would come down and he would have a chat, brief chat with staff and then ... he wouldn't stay hours but you know he would come, I would say once a week, once a fortnight.

Stephen Shaw: That is very helpful, that is all I wanted to know.

Ali McMurray: Shirley is there anything else you think we should know generally about healthcare in the prison or suicide prevention or anything really?

Shirley Boateng: Oh what I would ... like I said healthcare has improved quite a lot. We are still short of staff we would like to see, have more staff and I think we would be able to do much more, you know, we have many more skills now than we had before, nurses are now trained at doing sutures, phlebotomy and things like that, so it is, things are getting done much quicker than it used to because of the skills that the workforce have now. Having said that we are still short of staff but we are recruiting at the moment and hopefully we would get more staff. Training, they have got a good training programme going on now if nothing comes in its way I am hopeful that staff will be better equipped to do the work, you know, much more efficiently. I can't think of anything else at the moment.

Ali McMurray: Okay, that's great.

Shirley Boateng: I am . I am glad I have seen the new healthcare before I retire.

(LAUGHTER)

Ali McMurray: Shirley that's great, I am going to turn the tape off. Thanks very much.

Shirley Boateng: Okay.

1. I agree that this is a true and accurate record of my interview with Ali McMurray and Stephen Shaw on 11 July 2006.

Signed...

NAME IN CAPITALS...

Date...

2. I have read the above transcript and have placed amendments in the margins as shown.

Signed...

NAME IN CAPITALS...

Date...

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