Dying inside: deaths from natural causes in prison culture, regimes and relationships

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Abstract

This thesis considers what happens when a prisoner in England dies from natural causes. It explores the impact of deaths from natural causes on prison regimes, culture and relationships and demonstrates what determines the responses of prison regimes and personnel to dying prisoners. It is significant because to date there have been no studies of these deaths which considers their impact on the prison as an institution. Data collected using ethnographic methods in two prisons in the north of England in 2017 and 2018 shows how staff and prisoners understand the carceral geography of death and dying, construct the identity of the dying prisoner and define quality end of life care. Deaths in prison custody are seen to reflect the priorities of the prison regime, attitudes towards prisoners, and the dominance of the security imperative over issues such as care. The increasing frequency of deaths from natural causes in prison has led to changes to the institution regarded as long-term and enduring. These include the repurposing of space, changing work practices and the development of new concerns for staff and prisoners alike. The thesis concludes that, within limits, deaths from natural causes in prison custody soften the usual distinctions between what is expected or not expected, permitted or not permitted, between 'inside' and 'outside' prison. This is both tangible and intangible in prison regimes, culture and relationships and informs the responses of prison regimes and personnel to dying prisoners. The thesis challenges existing literature by demonstrating care quietly permeating through prison culture. It considers palliative care in prisons more holistically than existing studies, which are often limited to the medical care of terminally ill prisoners. It argues that in the perception of prisoners and staff, prison changes death, and death changes prison.

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Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references.

Chapter 1: Introduction

It is said that no one truly knows a nation until one has been inside its jails.
A nation should not be judged by how it treats its highest citizens, but its lowest ones.

Nelson Mandela[1]

Care for the dying, those who are important to them, their carers and the bereaved, is the measure of a compassionate society.

(National Palliative and end of life care partnership, 2015)

1.1 Background

England and Wales have the second highest imprisonment rate in Western Europe (141 prisoners per 100,000 of population) and a prison population which has increased by 70% in the last 30 years (Prison Reform Trust, 2018). What happens within prisons is more relevant than ever since it affects more of the population. However, at the same time as prisons have come under pressure from overcrowding, reductions in staffing and the need to implement changing government strategies, demographic changes are presenting new challenges associated with meeting the needs of elderly prisoners. There are now nearly three times the numbers of people aged over 60 in prison than there were 15 years ago (Ministry of Justice, 2018a), with 16% of prisoners aged over 50 (Ministry of Justice, 2018b) and as of 31 December 2016, 234 prisoners aged 80 or over (Ministry of Justice, 2017a), nearly all of whom had been sentenced after the age of 70 (HL WA, 27 Oct 2017). Ministry of Justice (2018b) projections for prison populations until 2022 suggest both the number and proportion of the population of prisoners over 60 years old will continue to increase. In making these predictions, the Ministry of Justice acknowledges a close association with the increases in prison sentences for sexual offences. Forty-five percent of men in prison aged over 50 have been convicted of sex offences (HL WA, 5 Jan 2017), a statistic which goes some way to explain these demographic changes. With an ageing prison population such as this, it is unsurprising the year to March 2017 saw the highest ever number of deaths in prison in England and Wales, nearly three fifths of which were due to natural

[1] Quoted in United Nations Office on Drugs and Crime (2015).

causes, as opposed to suicide or homicide (Ministry of Justice, 2017). Ministry of Justice (2018c) records show an increase in the rates of deaths from natural causes in prison, from 1.06 per 1,000 prisoners in 2006 to 2.43 per 1,000 prisoners in 2016. Deaths from natural causes, those caused by illness or a malfunction of the body rather than an external intervention, are not limited to older prisoners. Thirty-six percent of prisoners who died from natural causes in 2016 were under the age of 60 (Ministry of Justice, 2017b). Without changes in sentencing practice, or an overhaul of the compassionate release scheme for terminally ill prisoners, this trend for increasing numbers of prisoners to die of natural causes in custody seems likely to continue.

Despite the growing number of deaths of prisoners from natural causes, dying in prison is still an unusual experience. Across England and Wales, almost all deaths will be in other settings, typically hospitals, hospices, care homes or at home. Most people do not consider the possibility of dying in prison (Glamser and Cabana, 2003). If they were to do so, then they would probably conclude, with Aday and Wahidin (2016, p.314):

> *Behind bars one finds the possibility of dying alone, no family present to support you, no last goodbyes and no opportunity for reconciliations. For most people, dying in prison would be the least optimal environment on earth from which to choose.*

Studies of older men in prison have suggested dying in prison is seen as the ultimate failure (Bolger, 2004) and prisoners yearn to die as a free person (Crawley and Sparks, 2005).

Dying from natural causes in prison is not the same as dying from natural causes in other settings. (Aday and Wahidin, 2016; Burles et al., 2016; Handtke and Wangmo, 2013; Turner, Payne and Barbarchild, 2011; Wood, 2007; Dawes, 2002). Where age is a factor, older prisoners are in poorer health than their peers outside of the prison (Aday and Wahidin, 2016) and have poorer access to hospital services (Davies, Rolewicz, Schlepper and Fafunwa, 2020). The House of Commons Health and Social Care Committee's report on Prison Health found that deaths from natural causes in prison often reflected the poor physical health of the prison population and that prisoners sometimes experienced long delays in getting their health concerns addressed. (Health and Social Care Committee, 2018). The select committee heard evidence from the charity INQUEST that prisoner deaths categorised as resulting from natural causes were often premature and avoidable and found that prisoners in

England have a mortality rate 50% higher than the general public (Health and Social Care Committee, 2018).

Despite the higher mortality rate amongst prisoners and although deaths from natural causes now account for nearly three in five of all deaths in custody (Ministry of Justice, 2017b), they are rarely researched and receive little public attention. Current media discourses about the challenges faced by prisons in England and Wales focus on prison violence and the use of new forms of illegal drugs. Attention has understandably been paid to self-inflicted deaths and the small number of prison homicides, but the greater number of deaths from natural causes is overlooked. This oversight suggests a lack of awareness amongst researchers of deaths from natural causes in prisons and the questions they raise. The inadequacy of current research on deaths from natural causes in prison will be explored further in chapter two, when the scant existing literature is reviewed, but it is this context, of a growing number of deaths from natural causes in prison custody overlooked in existing research, which informs the purposes of this research project.

1.2 Rationale and aims

This research starts from the premise that whilst individual prisoners may find themselves facing an unwelcome death in an undesired setting, these deaths from natural causes have a wider impact inside the prison. The aim is therefore to critically engage with the impact on prison culture, prison regimes and prison relationships of the growing number of prisoners dying of natural causes, and to explore the factors influencing the responses within prisons towards dying prisoners. Two research questions will be addressed:

- How do deaths from natural causes in prisons impact on prison regimes, culture and relationships?
- What determines the responses of prison regimes and personnel to dying prisoners?

In doing so, consideration will be given to the extent to which deaths from natural causes challenge existing practices and assumptions within the prison. Attention will be paid to whether and how these challenges have repercussions for the wider prison. Of interest is whether they impact on the physical environment and resourcing of the prison, on staff identities and staff wellbeing, perceptions of prisoners, the implementation of prison rules and the provision of services: in short, the very nature of prison. This study therefore has a wider interest than the care of

the individual prisoner, but will refer to individual cases and to the observed and reported experiences of prisoners dying of natural causes. It will also refer to the contrasting situation: the aftermath of sudden, unexpected deaths. Given the paucity of studies of deaths from natural causes in prison, this aim is an appropriate one.

Whilst there may a lack of studies of deaths from natural causes in prison, the need for such research has been recognised. Liebling (2017, p.27) proposes:

> *deaths in custody are, and should be, controversial because they raise issues of accountability, legitimacy, and quality of life, including safety, as well as questions about the quality of death for those who die of natural causes in prison as a result of their age or sentence.*

This controversy alone should provide sufficient reason to research deaths in prison custody from natural causes. In addition, Girling and Seal (2016) claim that the "prisoners' loss of liberty places a heavy responsibility on the State to ensure that they are adequately cared for" (p.216). Arguably, the performance of this responsibility should be subject to scrutiny, through academic study as well as the investigations following individual deaths and the reviews by bodies such as the Prison and Probation Ombudsman. Although understanding the circumstances of individual deaths from natural causes in prison matters, the focus of this research is wider. Considering the impact of deaths from natural causes on prison regimes, culture and relationships, all wider units of interest, helps to address more structural factors. Considering these aspects is important because as Arnold, Liebling, and Tait (2007) suggest, "the prison as an *institution* tends to get less attention from researchers than prisoners" (p.484). Similarly, as Sykes (1958) argued: "the custodial institution — as a special type of social system — is a significant object of study in its own right" (p.xiv). Prison regimes, culture and relationships are all key aspects of the prison as an institution.

Studying deaths from natural causes in prison custody also matters from the perspective of death studies. Although few people will expect to die in prison, the unusualness and intensity of the prison environment provides new illumination on the familiar aspects of death and dying. However, criminological studies rarely consider deaths, other than those resulting from criminal activity such as murders, and the sociology of death typically overlooks death in custodial settings. This research project therefore aims to bring together literature from criminology, particularly that relating to punishment, with studies of death and dying because, as Girling and Seal (2016, p.267) argue:

> *Imprisonment can be said to be one of those sites/conditions where deaths and bereavement are intensified; for those inside (especially the vulnerable old, ill or life prisoners) the spacetime of prison is inscribed with the prospect of death, the contemplation of death and with the deaths of others.*

Their focus, however, is on the experience of the prisoner. The aim here is also to give an account of the experiences of staff in all roles and prisoners who have been involved in deaths from natural causes in prison custody. Prison officers have traditionally been overlooked in research about prisons (Liebling, Price and Shefer, 2011; Crawley and Crawley, 2008). Where prison officers have been the subject of academic studies, Liebling, et al. (2011) claim the focus has been on assaults and stress, to the neglect of their roles and working practice in other circumstances. Other staff working in prisons, including governors, chaplains, education staff and healthcare workers are also of relevance when considering how to address the research questions of this study. Considerations of gender were beyond the scope of this research and not relevant to the research questions. As will be seen gender was found to be of only minor significance in comparison with the importance of occupational roles in shaping attitudes towards dying prisoners and their care.

1.3 Personal story: insider status

My own awareness of prisoners dying of natural causes originates in having worked as a prison chaplain for nine years. Prison chaplains work in multi-faith teams to meet the faith, religious and pastoral needs of prisoners and are appointed to reflect the faith composition of the prison population. When I worked in a large category C prison, for those prisoners “who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt” (Garton Grimwood, 2015, p.4), the prospect of a death from natural causes was extremely rare. Talk of death was limited to the few elderly prisoners who found themselves in a category C prison as they neared the conclusion of life sentences. In my current role, at a high security prison for category A and category B prisoners, for whom the Ministry of Justice deems escape must be made impossible or at least very difficult (Garton Grimwood, 2015, p.4), significantly more of my time is spent on death-related matters.

In providing pastoral care for prisoners and staff, I have found myself discussing funeral plans with healthy prisoners who expect never to be released, supporting the efforts of terminally ill prisoners to find lost family members before it is too late, and sharing memories with other prisoners when one of their peers has died. I have on

several occasions visited seriously ill prisoners who have been transferred to hospitals for treatment, chatting to them and to the officers accompanying them. I have tried to meet their relevant practical and spiritual needs, within the constraints of the situation: everything from getting their reading glasses or favourite religious book sent out to them to discovering why they are refusing to eat. Once or twice, I have left the hospital having said what I expected to be a final goodbye. I have facilitated memorial services, sometimes in my own faith tradition, but also memorial gatherings that have reflected the wide range of beliefs of the deceased's friends. I have passed the private ambulance outside the prison as I have come to work, and wondered which of the many seriously ill men inside it has come for. I have stood in cell doorways, accompanying prisoners who cared for a man who has just died in the shock of their grief. I have spoken with officers trying to create a 'good death' for the next prisoner expected to die, whilst processing the paperwork and the expectations of an inquest from previous deaths, and I have tried to offer them support. And on one day as duty chaplain, I slipped away from my regular duties as often as I could to sit at the bedside and read aloud from the Bible of a dying prisoner, choosing yet another passage he had carefully bookmarked, unaware whether he could hear me or not. Eventually, on my final visit of the day, I was just in time to say prayers over his body before the cell door was locked pending the inevitable investigation. His death was the first I had witnessed. I am more familiar with the deaths of prisoners than I am with those of my own family.

Dying in prison is the "ultimate failure" (Bolger, 2004, p.139) and the "ultimate punishment (Aday, 2006, p.208), but it is one I would have been unaware of before working as a prison chaplain, despite it being a reality for a growing number of prisoners. Being a prison chaplain has given me a privileged insight, since chaplains occupy the space between prison officers (and arguably other staff) and prisoners (Hicks, 2012; Craig 2002). It has also brought me closer to the dying and dead than I expected. This personal connection has resulted in this research, making me aware of circumstances not addressed by existing research and leading me to look for explanations.

1.4 Boundaries and definitions

Although the site of a prison has a clear boundary, the walls and fences that physically enclose it, deaths in prison custody are not so neatly boundaried. Of the deaths from natural causes in prison custody in 2016 and 2017, 60% occurred in hospitals, hospices or nursing homes, with a small proportion occurring in the

ambulance travelling to the hospital (Ministry of Justice, 2018c). Some of the prisoners who die in these locations, outside of the prison, will have been granted release on temporary licence (ROTL) for medical reasons, but remain the responsibility of the prison (Ministry of Justice, 2018). Other prisoners, whose deaths occur within the prison buildings, may have received medical treatment prior to death in outside hospitals or hospices. In considering deaths from natural causes in prison custody, the limits of custody must therefore be extended to include prisoners in hospitals and hospices outside of the prison boundary.

Dying also has untidy boundaries. Glaser and Strauss (1968) are clear that the dying trajectory has a varying duration and different shapes, and is marked by critical junctures, with the dying person passing through transitional stages. The question remains for any individual: when do they start dying? As Glaser and Strauss (1968) point out, “dying must be defined in order to be reacted to as dying” (p.242). Some of the deaths from natural causes within prison will be unexpected, resulting from sudden catastrophic events such as strokes or heart attacks. In these circumstances, the prisoner will have been definable as ‘dying’, by themselves or others, for only a very short period. Other deaths will have been anticipated, resulting from a terminal diagnosis of conditions such as cancers, organ diseases or degenerative illnesses. In these circumstances, the individual or those around them may have regarded them as dying for weeks or months before death occurs. The definition of end of life included in the document *Ambitions for Palliative and End of Life Care; a national framework for local action 2015–2020*, (National Palliative and End of Life Care Partnership, 2015) provides one useful framework:

> *Patients are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with: a) advanced, progressive, incurable conditions; b) general frailty and co-existing conditions that mean they are expected to die within 12 months; c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition; d) life-threatening acute conditions caused by sudden catastrophic events. (National Palliative and End of Life Care Partnership, 2015)*

The National Palliative and End of Life Care Partnership definition of end of life helps set some limits on which prisoners’ experiences are relevant when considering how the prison regime and personnel respond to dying prisoners. However, in this research project, it was the participants’ understandings of when

someone was dying, to be discussed fully in chapter five, that was given priority. No attempt was made to identify which prisoners had a terminal diagnosis; the emphasis was on how participants defined dying.

Given this research looks at how deaths from natural causes impact on prison regimes, culture and relationships, it is important to provide definitions of these terms. A prison regime is essentially how things are done in a particular prison, the ways in which the prison is organised and run, including both formal and less formal systems. There is a close link with the culture of the prison as a whole, but the prison regime is essentially about the system of order, governance or control in operation within the establishment, informed by the regulations, rules and guidance that shape prisons in general, but also by the informal practices present in the particular institution. In this respect, it closely matches the Oxford English Dictionary (2009) definition of a 'regime' as a:

> *method or system of rule, governance, or control; a system of organization; a way of doing things, esp. one having widespread influence or prevalence.*

The regime attempts to set the culture of the prison, but as well as having their own regime, individual establishments also have their own culture (Crewe, 2009; Liebling, 2008; Arnold, Liebling and Tait, 2007; Leggett, 2002) within which there are a number of subcultures, including prisoners' social structures and staff occupational cultures as well as forms of resistance to the regime. Different areas within a prison could also have their own cultures (Nylander, Lindberg and Bruhn, 2011; Liebling, Price and Elliot, 1999; Cohen and Taylor, 1972), prison culture being the informal and formal social organisation of the prison (Clemmer, 1958). Lastly, the importance of relationships within the prison should not be understated. This includes relationships between prisoners, but it is the relationships between prisoners and staff that are usually regarded as most significant. The Home Office Control Review Committee (Home Office, 1984) statement is often quoted (Liebling et al., 2011; Hay and Sparks, 1991), usually to refer to prison officers' relationships with prisoners:

> *At the end of the day, nothing else that we can say will be as important as the general proposition that relations between staff and prisoners are at the heart of the whole prison system and that control and security flow from getting that relationship right. Prisons cannot be run by coercion: they depend on staff having a firm, confident and humane approach that enables them to maintain close contact with prisoners without abrasive confrontation.* (1984, para. 16)

These relationships are central to the moral quality of prison life and decisive in shaping the climate of the prison (Liebling, 2011). How they are affected by the circumstances of a dying prisoner is therefore highly relevant.

The quality of relationships is evident in the terminology used by staff and prisoners towards each other. Throughout this thesis, those held in prison custody will be referred to as 'prisoners', or, since the prisoners in this research project were all male, by male pronouns. Coyle (2012) argues the terminology used in the context of prisons is often intended to soften reality, but is actually indicative of how people held in prison are regarded. He describes 'inmate', used in the late twentieth century as having medical overtones, and 'offender' as restricting understanding of all aspects of the person to one aspect of their behaviour. Instead, Coyle (2012) provides a strong case for the term 'prisoner' as the most appropriate, since it reflects the deprivation of liberty inherent in the punishment of imprisonment. The prisoners at HMP Wakefield provided a further reason why 'prisoner' should be the term used. During the fieldwork for this research, a poster in a busy area of the Centre asked, "what would you like the prison to call you?" Plastic counters were provided to use to 'vote' in boxes labelled 'inmate', 'prisoner' or 'resident'. The results were 249 votes for 'prisoner', 229 for 'resident' and 62 for 'inmate'.

As is common in any social setting, the prison has its own terminology, neologisms, slang and jargon. Where the use of these is unavoidable, or adds to understanding, the terms has been included in a glossary at the end of the thesis.

1.5 Thesis structure

This thesis is structured in seven chapters. The first two chapters, including this one, establish the aims and objectives of the research. Chapter two offers a review of the extant literature, beginning with deaths in the criminal justice system, before focussing on prison-specific issues including prison regimes, rules, personnel, culture and relationships. This literature review concludes by examining what is already known about deaths from natural causes in prison, focusing on studies of prisoners' attitudes towards death, the provision of palliative care in prison and the experience of prisoners bereaved by the death of a peer in this way. Chapter three provides an outline of the methodological approach taken in this research. It establishes the research strategy and the process of data collection and analysis. This chapter also conveys the ethical considerations inherent in a study involving both vulnerable participants and a sensitive subject.

The findings of this research are presented in three chapters, bringing together the factors determining the responses to dying prisoners with the impact these deaths from natural causes are seen to have on the prison regimes, culture and relationships. Essentially, what is being considered in these chapters is how prison changes death, and how death changes prison. Imprisonment is conceptualised as more than being inside prison walls, in an austere indoor setting of locked gates and doors. Imprisonment also has a psychological dimension, the deprivations of imprisonment bringing their own pains at the end of life in circumstances where the individual's actions are largely governed by the rules of the prison service and by prison personnel. In this regard, prison is both tangible, the place of incarceration, but also intangible, the situation resulting from 'rules' or symbolically embodied by the escort chains or barred windows that serve as reminders of imprisonment. Discussions of the role of prison officers will feature throughout these chapters, since they "play an influential role in the lives of many inmates because of their direct and prolonged interaction" (Farkas, 2000, p.431), but the role of other prison personnel will also be seen to be significant. This includes not just healthcare staff who may have direct contact with seriously or terminally ill prisoners but others such as chaplains, education workers or the governors whose authority determines many actions. In modern prisons, it is unhelpful to regard all prison officers as performing the same task. Some will have specific, often additional functions, including the family liaison officers who have a central role relating to prisoners' families around a death. Uniformed officers will also operate as 'middle managers', custodial managers participating in many of the same functions as governor grade staff. A number of themes will reoccur, including stigma, autonomy, discipline and control. The focus throughout is on how participants are constructing their understandings of the situations they are experiencing, influenced by their social contexts, in this case the prison, but also their experiences outside of the prison. Differences arise between the two prisons studied which will be highlighted when relevant. These result not just from the differing purposes of the two prisons, but also the different experiences of prisoners' deaths from natural causes.

Chapter four provides an overview of the physical locations in which deaths from natural causes in prison custody may occur and the rules governing these locations. The carceral geography associated with these deaths and the four spaces in which dying and death in prison custody occur will be outlined. This includes the prison wing (the principle residential site for prisoners), prison healthcare centres, any palliative care suite provision within the prison and hospitals or hospices where the

prisoner may be transferred. Where dying prisoners are located whilst in prison custody is informed by ideas within the prison about the nature of prisoners and imprisonment, and the expected power relationship between prisoners and prison personnel. Beyond the way in which the physical environments of dying in prison may change the experience of death, the spatial arrangements of dying will be seen to be affected by the experience of imprisonment, of being subject to a regime intended to discipline and control. The spatial arrangement of the dying also serves to provide information to others about the dying trajectory of the individual (Glaser and Strauss, 1968). This in turn influences responses to the individual, and plays a role in revealing how a prisoner is constructed as dying, something that will be discussed further in chapter five. Next, this chapter considers the rarity of release for terminally ill prisoners, which results in the prison regime rather than the community having to respond to their dying, and the impacts of these deaths consequently resonating within the prison. Lastly, the prison rules, regulations and guidance relating to deaths from natural causes and the circumstances around terminally ill prisoners and those working with them will be considered. These shape not just the practical activities around the dying or deceased prisoner, but also reflect and direct the discourses that surround a prisoner at the end of life and after a death. The dominance of such rules, regulations and guidance is a particular feature of deaths in prison custody. Specific aspects of how prison rules, regulations and guidance shape deaths from natural causes will be further explored in the subsequent chapters.

Chapter five looks at the constructions of the individual as both dying and as a prisoner. It is suggested more frequent deaths from natural causes — and the anticipation of further such deaths — have changed prison culture, such that the dying is no longer unusual and death is regarded as a less sensitive subject than might otherwise be expected. This chapter also considers self-constructions as a dying prisoner, using examples of prisoners speaking about their expectations of dying in prison. Particular attention will be paid to the tensions arising from differing occupational identities between staff as to whether the dying individual is a ‘patient’, ‘prisoner’ or ‘person’. Following this, consideration will be given to how the dying or deceased person is understood if their dominant status is as a ‘prisoner’. This includes the impact of stigma on the way in which prisoners who are terminally ill are figured by the prison personnel working with them. The construction of the prisoner as someone who is potentially dangerous, who poses a risk because of their past behaviour, relates closely to the overarching importance of security considerations

which emerges strongly from the data. The ways in which this imperative affects understandings of prisoners directs the ways in which prison regimes and personnel respond to the dying. However, it will also be apparent some of the adjustments made around dying prisoners challenge the pre-eminence of security concerns by reflecting other agendas, albeit only at the very end of life. The deprivation of autonomy which Sykes (1958) identified as resulting from imprisonment is also relevant here. Following this, it is suggested that seeing the ‘patient’ or ‘person’ changes the experience of dying for the prisoner, since more sympathy may be afforded them. However, it will also be shown dying prisoners can be constructed in ways that retain the stigma of imprisonment, with some staff regarding some prisoners as being beyond sympathy. The reasons for this will be explored, together with alternative recipients of sympathy, namely the prisoner’s family, who may provide a more palatable focus for staff engaged in the emotional labour of constructing a prisoner as someone deserving of sympathy. Finally, attention will be given to the status awarded the dead body of a prisoner and the extent to which prisoners who have died are regarded as worthy of being grieved. Memorialising the dead has become one of the new tasks of prison staff and prisoners, but is not without its controversies.

Chapter six focuses on understandings, expectations and definitions of quality care with regard to dying prisoners, and to a lesser extent in respect of staff and the prisoner’s peers potentially affected by a death. For dying prisoners this includes medical care, delivered primarily through the prison’s healthcare team, but also social, psychological and spiritual care, crucial in the WHO definition of good palliative care. How prison culture and relationships reflect the need to provide care for the seriously and terminally ill will be discussed, together with the role of other prisoners, employed as carers, in creating a caring community around the dying. Examples from the prisons studied will show care to be socially constructed and heavily influenced by the prison setting. Three different frameworks for evaluating the care provided will be considered: the ideal of ‘equivalence’; the motivation of some to make end of life care in prison ‘as good as it could be’ as a transaction with another human being, and the impact of expectations of an investigation after a death.

Looking at how care is delivered reveals the practical differences resulting from the fact of imprisonment. These include difficulties in maintaining medical confidentiality, of communicating a prisoner’s wish not to be resuscitated, of ensuring privacy and

of meeting physical, psychosocial and spiritual needs at the end of life in a prison setting. Responding to these will be seen to necessitate a number of adjustments to the usual prison routine, typically made through the use of discretion. Discretion plays a significant part in the criminal justice system, but here it is part of finding creative solutions to changing needs, albeit exercised within the assumptions about discretion in the hierarchical setting of a prison. Several examples of adjustments from the prison studied will be provided, but evaluating the use of discretion also highlights the danger of discrimination or arbitrariness.

One of the unexpected impacts of deaths from natural causes in prison is the changed relationship with prisoners' families. This will be explored in the context of prison staff extending care to bereaved families. Lastly, the care prisoners and staff provide for their peers around a death will be discussed, including examples of needing, providing, and receiving or not receiving care when affected by a prisoner's death.

Finally, chapter seven will offer some conclusions and reflections on the research, linking the findings closely to the two research questions, evaluating the effectiveness of the research project and offering some suggestions for further research. This chapter will demonstrate the original contribution of the research to the existing literature and the importance of considering deaths from natural causes in prison custody.

Chapter 2 Literature review

2.1 Introduction

Academic research about prisons has traditionally overlooked questions around prisoners dying from natural causes. It has instead focussed on the majority of prisoners, those who will be released, and the circumstances in which they are kept until then. Classic studies such as Sykes (1958), Clemmer (1958) and Irwin (1970) describe the conditions and experience of imprisonment and the prison culture in the US, but share an assumption that the prisoners they describe will at some point be released. In the UK, another significant text, by Cohen and Taylor (1972), looks at the experience of long-term prisoners, addressing questions around their psychological survival, without considering the possibility of death in prison. More recent landmark studies, such as Crewe (2009), have shed new light on the experience of imprisonment, but not addressed the experience of deaths from natural causes whilst imprisoned. When deaths of prisoners are considered, the emphasis has traditionally been on deaths resulting from suicide or occasionally as a result of homicide, not deaths from natural causes (see Carlton and Sims, 2018; Liebling and Ludlow, 2016; Crighton, 2002; Sattar, 2001; Liebling, 1999; Towl and Crighton, 1998; Bogie and Power, 1995; Liebling, 1991; Dooley, 1990; Topp, 1979).

Contemporary studies of prisons acknowledge prison staff are key to the development of prison culture and relationships, and to the operation of the regime. As such, much research attention is paid to how the roles of prison officers, governors and others are defined, including the effect of gender. There has also been research exploring the relationships between staff in various roles and prisoners, including how they perceive each other, and in what circumstances this perception may change, as well as studies of the prisoner culture. The use of discretion is a perennial issue in prison studies. However, there is still virtually no consideration of the impact of dying prisoners on these aspects of the prison. The ways in which deaths from natural causes may require new definitions of staff roles or particular forms of emotional labour, change relationships and cultures or challenge the exercise of discretion and the balance between control and care have not been considered. Similarly, whilst studies of palliative care in prisons exist, particularly in the US (see Supiano, Cloyes, and Berry, 2014; Wright and Bronstein, 2007; Linder and Meyer, 2007; Maull, 1991), the attitudes of prisoners to the deaths of their fellow prisoners have been neglected by researchers. In order to situate the research questions in a broader academic context, it is therefore necessary to consider themes which address deaths in the criminal justice system and the issues

associated with prison regimes, culture and relationships more generally. It was not felt necessary to consider deaths in institutions outside of the criminal justice system since several key characteristic of prisons and imprisonment are rarely found in combination outside of the criminal justice system. These include the loss of liberty, the importance of the security imperative, the individual's history of offending, the routine use of physical restraint and the state's duty of care. Consequently, the existing literature will be reviewed in relation to four linked themes.

Firstly, consideration will be given to the data and existing research on deaths within the criminal justice system, looking at both custodial and non-custodial settings. This will include non-natural deaths in prison custody, but also deaths occurring in police custody and amongst offenders, including ex-prisoners, who are under community supervision. Next, what is understood in the literature by the prison regime and the nature of prison regimes will be examined, including how regimes may vary. As part of this, studies of the component parts of a prison regime, the rules and personnel, will be reviewed. This will include governors, prison officers, and other staff who are expected to be in contact with dying prisoners, including healthcare professionals within the prison and prison chaplains. In looking at the literature on prison rules, research on the role of discretion within prisons also becomes relevant. Attention then turns to the literature on prison culture, including prisoner and prison officer cultures, reflecting the two main groupings within the prison. As part of this, the literature on relationships between staff and prisoners will be discussed. Consideration will also be given to the place of care and caring within the prison culture, looking at the work of prisoners employed as carers and reflecting the importance of a perhaps unexpected aspect of prison culture to the experience of terminally ill prisoners. Finally, attention will turn to the limited literature on death and dying from natural causes in prison, including the provision of palliative care in prison by both healthcare professionals and other staff such as family liaison officers and chaplains. This section also considers the existing research about prisoners' attitudes to death and dying in prison custody, as well as the experience of bereavement and grief amongst prisoners when a colleague dies.

Since criminal justice systems differ around the world, most attention will be paid to academic research looking at the situation within England and Wales, where the fieldwork for this study was conducted. Consideration will be given to research from other criminal justice systems, particularly the US, where larger numbers of prisoners dying from natural causes in custody have resulted in more academic attention on this issue. However, significant differences in sentencing, prisoner

demographics and prison conditions between the US and England and Wales place limits on the usefulness of academic studies which focus entirely on the US criminal justice system.

2.2 Deaths in the criminal justice system

When deaths in the criminal justice system in England and Wales are considered in academic studies, the focus is on three main areas: the prison, police custody and community supervision, and the greatest attention is paid to self-inflicted or violent deaths. Phillips, Gelsthorpe and Padfield (2019) argue, "a death might occur at any point along the criminal justice 'process' and this contact with 'criminal justice' might be relevant to the death" (p.161). One common feature of these deaths is the requirement for them to be officially recorded and scrutinised by independent investigation procedures. As a result, many of the studies of deaths in the criminal justice system draw heavily on statistics collected by the Home Office, the Independent Police Complaints Commission, the National Offender Management Service or similar bodies.

As Phillips, Padfield and Gelsthorpe (2018) point out, there is a long history of concern about the number of people who die in prison or police custody in England and Wales, which is heightened when these deaths result from non-natural causes. This review of the literature on deaths in the criminal justice system will begin therefore by considering deaths in prison custody and then police custody, before considering an area that receives arguably less attention, deaths under community supervision. Throughout, contact with the criminal justice will be seen to be associated with higher mortality rates than in the general population, and deaths from non-natural causes will be seen to dominate academic research in this area.

Prison custody

Deaths in prison have been subject to scrutiny by governments, charities and academia for many years (Phillips, Gelsthorpe and Padfield, 2019; Liebling, 1999). However, very few studies of deaths in prison from natural causes exist, perhaps because as Richard Tilt (1998) former Director General of the Prison Service said, arguably erroneously, "of all the kinds of deaths those by natural causes are perhaps the easiest to understand". The limited literature will be discussed later in connection with research on prisoners' attitudes towards deaths, grief and bereavement in prison and the provision of palliative care to prisoners. Instead, non-natural deaths, particularly self-inflicted deaths and suicides, tend to attract more

attention. Even when the literature purports to be looking at deaths from all causes, such as Snow and McHugh's (2002) study of the aftermath of a death in prison custody, or Carlton and Sim's (2018) study of deaths "in sites of state confinement" (p.54), deaths by suicide dominate the data and the discussions.

Crighton (2002) acknowledges the methodological problems of studying suicides in prison. He finds many early studies often failed to define their terms, second-guessed the causes of deaths when the coroner's court had proved inconclusive and lacked control groups. Nevertheless, he suggests several themes emerge. Crighton (2002) finds several studies (Towl and Crighton, 1998; Bogie and Power, 1995; Liebling, 1991; Dooley, 1990; Topp, 1979) show that the early stages of prison custody present the highest risk of suicide, the risk of suicide increases with the length of prison sentence and the length of time spent in a single establishment is significant in the risk of suicide.

Liebling and Ludlow (2016) provide a different summary of prison suicide studies, proposing that prison suicide is often theorised using an importation model, where previous characteristics predisposing an individual to suicide are imported into the prison with them, as opposed to a deprivation model, where the deprivations of imprisonment are seen to increase suicide risk. Liebling (1999) highlights that large numbers of prisoners have characteristics which in the general population are linked with an increased risk of suicide, such as alcohol and drug addiction, poor educational achievement, low self-esteem, negative personal relationships, adverse life events and poor problem-solving ability. Similarly, Tilt (1998) writing as the then Director General of the Prison Service, argues prison suicides are not exclusively an issue for prisons, but reflect what happens in individuals' lives outside of the prison. However, whilst stating "arguably, the prison population is almost selected to be at risk of suicide" (Liebling, 1999, p.x). Liebling concludes the prison experience of particularly vulnerable groups needs to be better understood in connection with prison suicide. Similarly, in a later study with Ludlow (Liebling and Ludlow, 2016) she advocates a theory of prison suicide which combines importation and deprivation models to explain prison suicides as the result of both individual characteristics from before imprisonment and extreme distress at the experience of imprisonment.

Research attempting to explain the causes of prison suicides often focuses on prison-related factors, although does not always concur over their influence. Fazel, Ramesh and Hawton (2017) find no association between prison-related factors such

as overcrowding, prisoner to staff ratios, expenditure on prisons, turnover rates of prisoners or length of prison sentences. Instead, their study of 24 high-income countries finds a correlation between the general population suicide rate and the rate of suicide in prisons, which is typically three times higher for men and nine times higher for women than in the outside community. This partially contradicts Van Ginneken, Sutherland and Molleman (2017), whose exploration of Ministry of Justice data for 2000–2014 finds overcrowded prisons seem to have a higher suicide rate but say this may relate to prison function, security levels, population size and the turnover of prisoner population. Larger prisons with higher turnovers and increased security measures, especially if they are in public sector management, are found by Van Ginnekin et al. (2017) to have a higher suicide rate. Controlling for these factors suggests to Van Ginnekin et al. (2017) that overcrowding is not a factor. Liebling and Ludlow (2016) disagree, saying overcrowding is a factor because it leads to problems such as lack of access to medical care, lack of activity within the prison and increased misconduct and assaults, which in turn increase the suicide risk amongst vulnerable prisoners. For them, increased levels of distress are the main cause of prisoner suicide. Liebling and Ludlow (2016) attribute the increased number of suicides in prisons in England and Wales between 2012 and 2014 to rapid prison population expansion, major organisational change and reduced predictability and safety in prisons. They argue the treatment of prisoners can affect their levels of distress, with safe prisons, where prisoners are treated with dignity and personal development and meaningful contact are facilitated, resulting in less distress among prisoners. This echoes earlier work by Liebling (1999) where she argues the trauma induced by the experience of imprisonment could overwhelm an individual's ability to cope.

Liebling and Ludlow's (2016) analysis of the role of distress in prisoner suicides leads them to conclude suicide prevention should be reconceptualised as the promotion of wellbeing. Other studies highlight the importance of high quality staff-prisoner relationships in enabling prisoners to report suicidal feelings and suggest it is unhelpful to label people as "poor copers" (Towl and Forbes, 2012, p.99). One criticism of how prisons manage suicide risk is that an undue emphasis is placed on the process, whereas in reality staff exercising professional discretion and the quality of staff-prisoner relationships are key (Ludlow, Schmidt, Akoewi and Liebling, 2015). Carlton and Sims, (2018) however, from an abolitionist perspective, argue prisons, as a site of state confinement, inherently exercise institutional power that is

destructive and can leave all prisoners feeling bereft and placed on a continuum of terror and violence.

Several studies comment on the effect on staff of prison suicides. Whilst Carlton and Sims (2018) assert the occupational culture within sites of state confinement gives staff a sense of impunity, other studies (Ludlow et al., 2015; Towl and Forbes, 2003; Snow and McHugh, 2002) conclude there is a significant emotional dimension for staff working with suicidal prisoners. Ludlow et al. (2015) conclude that staff are seeking an achievable model of good practice with regard to suicide prevention but are frustrated by a lack of time to provide personalised, integrated care. Their study finds the emotional and practical effects of involvement in a prisoner suicide can leave staff less effective at managing future self-induced deaths. Snow and McHugh (2002) similarly find a prisoner's suicide can result in the staff involved engaging in considerable soul-searching, looking for signs and symptoms they missed. They conclude being the first staff member on the scene of a suicide can be profoundly affecting.

Deaths in prison custody resulting from homicide are very rare in England and Wales (Sattar, 2001; Dooley, 1990) which perhaps explains why they are overlooked in the literature. Dooley (1990), looking at deaths in prison custody between 1972 and 1987, reports on only 16 homicides in prison, suggesting this rate is lower than in the US because of different methods of control and security between the UK and US. He suggests the UK practice of supervising not just the periphery of the prison but also the behaviour of prisoners within the prison maintains an impressively low homicide rate given a population characterised by violent behaviour. Sattar (2001) is not willing to engage in comparing homicide rates across prison systems in different countries. Her study on behalf of the Home Office finds between 1990 and 2001 there were 26 prisoner-on-prisoner homicides in England and Wales, 35% of which occurred in high security establishments. All the victims were male, their mean age was 31 years and most of them were white. In 18 of the cases a motive was given, with the most common motivation being an argument, although in two cases the nature of the offence was a factor. Half of all homicides in Sattar's study occurred in shared cells, although she acknowledges sharing a cell can reduce the risk of deaths by suicide and that cell-sharing risk assessments are now in place. As with Liebling and Ludlow (2016) on prison suicides, Sattar (2001) links deaths from homicides in prison to overcrowding and the resultant stress on prisoners.

Police custody

Research on deaths in police custody is less common than on deaths in prison custody and tends to be dominated by studies for the Independent Police Complaints Commission (see Hannan, Hearnden, Grace and Bucke, 2010) and the Home Office (see Leigh, Johnson and Ingram, 1998). Deaths in police detention however, are regarded as extremely important areas of concern because they attract public controversy (Chan, 2016; Hannan et al., 2010; Heide and Norfolk, 1998). As Chariot and Heide (2018) argue: “any case of death or harm in custody, whatever the cause or circumstances, may raise concerns of police misconduct, the reality of which may be unclear because of limited or inaccurate information enhanced by media coverage" (p.55). Hannan et al. (2010) argue such deaths may have a particularly negative impact on trust and confidence in the police among BAME communities.

The Independent Office for Police Conduct (2018) defines deaths in police custody as those occurring during or following police contact, or which happen while a person is being arrested or taken into police detention. This definition includes deaths of individuals held under the Mental Health Act of 1983, and deaths occurring on police, private or medical premises (such as a hospital), in a public place or in a police or other vehicle. It includes cases where injuries sustained during a period of detention contributed to death, where the death occurred whilst the detainee was being transferred to hospital and where the injuries or medical problem were identified or developed whilst the person was detained (Independent Office for Police Conduct, 2018). Extant research relies heavily on this definition or earlier similar versions (Hannan et al., 2010; Norfolk, 1998).

Two studies provide detailed analysis on quantitative data about deaths in police custody. Leigh et al. (1998) find that between January 1990 and December 1996, 380 deaths occurred in police custody, although having excluded those where they identify police involvement was tangential or little information was available, examine only 270 of these cases. They find 63% of deaths were due to the deceased own actions, and 29% due to medical conditions. They identify a number of reoccurring themes in the circumstances of a death in police custody, including head injuries being interpreted by custody staff as drunkenness. According to Leigh, Johnson and Ingram (1998), the overall death rate is 3.2 per 100,000 notifiable offences.

In contrast, Hannan et al. (2010), looking at deaths in police custody between 1998–1999 and 2008–2009, find the number of deaths per year has declined over time, but that the rate of deaths per 100,000 notifiable arrests varies between police forces. In their study, the most common reasons for arrest amongst those who died are linked to the detainee being drunk, incapable or disorderly, and to public order or driving offences, and the most common causes of death are natural causes and overdoses, with suicides and injuries prior to death also contributing to fatalities. In their sample, 72% of deaths were linked to drugs or alcohol. Norfolk (1998) finds that 11 of the 32 deaths occurring in 1994 were associated with alcohol, with two of these deaths involving a head injury and intracerebral bleeding which was identified by a doctor at the police station but led to the detainee dying in hospital.

As discussed below in the context of palliative care in prison, the use of restraining methods of police detainees attracts particular attention, although in these circumstances as a contributory causal factor in deaths in prison custody. Heide Chariot, Green, Fabian and Payne-Jones (2018) suggest different forms of restraints pose a risk to detainees. Chariot and Heide (2018) find inconsistencies across Europe in the training of police officers on the use of restraints. Several studies, including Hannan et al. (2010), draw attention to statistics on the use of restraints on detainees who subsequently died, finding that between 1998–1999 and 2008–2009 5% of deaths (16 cases) in police custody were related to restraints, with four out of the 16 individuals dying as a result of positional asphyxia. Leigh et al. (1998) find a slightly higher number (6%) of deaths in police custody between 1990 and 1996 to be potentially associated with the use of police restraints. They suggest drugs may play a part in restraint-related deaths, with detainees who are intoxicated being more likely to resist police officers and more susceptible to harm.

Detainees are regarded as a vulnerable group (Heide et al., 2018), more likely than the general population to experience underlying issues such as drug or alcohol misuse, mental health problems or poorly controlled physical health problems. However, Heide et al. (2018) and other studies identify a number of ways in which the actions of custody officers and staff could have contributed to the number of deaths in police custody. Hannan et al. (2010) report on missed risk assessments, a failure to check on detainees even when this has been identified as needing to be done regularly and a lack of first aid training in staff. Leigh et al. (1998) emphasise the importance of police custody staff being alert to statements of suicidal intention, and of officers being careful to search detainees for any drugs or medication that

could cause them harm. Norfolk (1998) also calls for suicide awareness training for custody staff and the medical professionals called to assess detainees' fitness. Additionally, Norfolk (1998) recommends the installation of video surveillance in police cells. McKinnon, Thomas, Noga and Senior (2016) report deaths in police custody decline when attention is paid to the potential for the detainee to be affected by drugs and alcohol, whether through intoxication or withdrawal, and argue for evidence-based screening tools to increase the detection of morbidities. They regard high profile deaths in police custody in England and Wales as having led to renewed effort to identify risks and vulnerabilities as soon as possible after arrest or detention, and a subsequent reduction of deaths in police custody in the decade to 2015, including of confirmed suicides.

Community supervision

A number of studies consider deaths within the criminal justice system which occur in the community. This includes people sentenced to community supervision orders as well as former prisoners released on probation. Studies typically argue these deaths in non-custodial settings are neglected (Phillips, Padfield and Gelsthorpe, 2018; Jones and Maynard, 2013; Pratt, Piper, Appleby, Webb, and Shaw, 2006; Sattar, 2003) with Phillips, Gelsthorpe and Padfield (2019) claiming "deaths outside custodial setting are less understood and receive much less scrutiny and public attention than equivalent deaths that occur in custody" (p.160). They attribute this to policy, methodological and societal issues. However, several studies do exist which consider deaths in community supervision in England and Wales (Philips, Gelsthorpe and Padfield, 2019; Phillips, Padfield and Gelsthorpe, 2018; King, Senior, Webb, Millar, Piper, Pearsall, Humber, Appleby and Shaw, 2015; Jones and Maynard, 2013; Pratt et al., 2006; Mills, 2004; Pritchard, Cox and Dawson, 1997). The focus of these studies is predominately on self-inflicted deaths rather than deaths from other causes, perhaps understandable given the mortality rate for deaths from natural causes is the same for people under probation supervision as for the general public (Gelsthorpe, Padfield and Phillips, 2012).

There is widespread agreement among published studies that contact with the criminal justice system in non-custodial settings leads to a higher rate of mortality from non-natural causes than found in the general public. Phillips, Padfield and Gelsthorpe (2018) report the suicide rate for men under supervision as six times that of the general population and a ratio of 29.2 for deaths of women under supervision compared to the general population. For both genders, there was a higher ratio of

suicide under supervision when compared to the general population than suicides in prison when compared to the general population. Pritchard, Cox and Dawson (1997) find that amongst male offenders aged between 17 and 54 years, the death rate is twice that of the general population and the suicide rate nine times higher. Their study is however very small, considering only 28 deaths between 1990 and 1995 in one English county, Dorset, and as with other studies, focusses on suicide and violent death, neglecting the six people in this cohort who died of natural causes. Using a bigger dataset (the Office for National Statistics data on all adult deaths in England and Wales in 2005) and linking it with data from the UK police authority on criminal records, King et al. (2015) report that 13% of suicides in the general population are people who were in community justice pathways less than 12 months before their deaths. They find suicide is highest amongst people who have received police caution or have recent or impending prosecutions for sexual offences.

Between 2006 and 2010, Gelsthorpe, Padfield and Phillips (2012) find that not less than 13% of deaths per year under probation supervision were by suicide, 8% (when figures were available) were linked to alcohol issues, and 5% were as a result of unlawful killing. A large number, not less than 15%, were due to 'unknown' causes. Women under probation supervision were more likely to die from alcohol-related issues, men from suicide, drug overdose, accidents or as a result of unlawful killing. People aged 25–49 or over 50 were over-represented in the deaths. In a more recent study, Phillips, Padfield and Gelsthorpe (2018), using data from the Ministry of Justice, report that of the 726 deaths of offenders in the community in 2015–6, 264 of these deaths were self-inflicted, 68 were accidental and 22 were apparent homicides. Their focus is on the deaths from suicide, although natural causes accounted for 371 deaths.

In the dataset Phillips, Padfield and Gelsthorpe (2018) use, 372 deaths were of individuals following release from prison. Some studies focus exclusively on the mortality of released prisoners under community supervision. A systematic review by Jones and Maynard (2013) found nine studies (in Australia, the UK, US and Finland) on the suicides of recently released prisoners. Their meta-analysis of five of these studies finds an increased level of death from suicide among released prisoners, 6.76 times that of the general population. Pratt et al. (2006) also find recently released prisoners are more at risk of suicide than the general public, reporting a suicide rate of 156 per 100,000 people, with 21% of suicides occurring within 28 days of release.

Sattar (2003) draws comparisons between deaths on community sentences and deaths in prisons, suggesting prisoners and offenders in the community are similarly vulnerable to self-inflicted death but the risk of accidental death or homicide is higher among community offenders. Her study compares the circumstances of the 236 deaths of prisoners with the 1,267 deaths of offenders or ex-prisoners supervised by the probation service in England and Wales in 1996–7. She identifies drugs and alcohol as more significant in the deaths of offenders in the community, attributing this to them being more readily available in the community than in prison. Sattar (2003) also comments on differences in the methods of suicides, with only 9% of self-inflicted deaths of community offenders in her study being as a result of hanging, compared to 54% of suicides in prison. She finds ex-prisoners are most likely to die within one week of leaving prison, with accidental or non-natural deaths being the most common in this group. However, community offenders were found to be more vulnerable to violent death than prisoners.

Some studies suggest reasons for the elevated risk of suicide among individuals under community supervision. Jones and Maynard (2013) suggest the higher suicide rate among released prisoners is probably linked to the higher levels of mental illness documented within prison together with the stress experienced when transitioning from the prison to community. Mills (2004) further suggests offenders, and drug-using offenders in particular, have lives which inherently place them at higher risk of harm. She finds the probation service does little to promote the harm reduction practices that would reduce drug-related deaths. Similarly, Phillips, Gelsthorpe and Padfield (2019) conclude people under probation supervision have poor physical and mental health and often chaotic lives and suggest that chaotic arrangements for the supervision of offenders in the community are having a negative impact on their well-being.

As with studies of prison suicides, one of the issues for researchers looking at deaths on community sentences is the lack of detailed datasets. In their study, Phillips, Padfield and Gelsthorpe (2018) identify gaps in the data published by the Ministry of Justice. They conclude Her Majesty's Prison and Probation Service (HMPPS) data, compiled using forms completed by probation providers after a death, could be used to calculate suicide rates, but not to address the underlying risks faced by people on probation or to explain why the mortality rate amongst people involved in the criminal justice system was higher than the general population. There are also variations in how self-inflicted deaths are defined, with

some deaths reported as ‘apparent’ suicides rather than being confirmed by a coroner’s inquest or death certificate. Philips, Padfield and Gelsthorpe (2018) suggest further research is needed to match government data sets to produce a more comprehensive quantitative analysis, and that qualitative data, including interviews with attempted suicide survivors and with family members of people who have died under community supervision, is also needed. A number of authors call for action, including Jones and Maynard (2013) who argue that in order to better support released prisoners, prison, probation providers, social and healthcare services need to provide a more holistic service.

Whilst there are several studies of suicide in prison, and a few studies of homicide in prison, along with research on deaths in police custody and amongst offenders under community supervision, the absence of research on deaths from natural causes is striking. Tilt’s (1998) comment that “of all the kinds of deaths those by natural causes are perhaps the easiest to understand” reflects a focus in studies of deaths in the criminal justice system on identifying the causes of deaths, rather than exploring the experience of deaths. What literature does exist on how prisoners regard dying in prison, on the provision of palliative care within prison and on the experience of bereavement in prison will be considered later in this chapter. However, in order to better understand deaths from natural causes in prison, it is important first to consider the context in which they occur, specifically the prison regime, culture and relationships which are key to the research questions for this project.

2.3 Prison regimes: people and rules

The concept of a prison regime is relevant to the research questions which seek to understand what determines the responses of prison regimes to dying prisoners and how deaths from natural causes impact on prison regimes. Most studies of prisons refer to the ‘prison regime’ but the term is often used vaguely. Her Majesty’s Chief Inspector of Prisons for England and Wales (1992, p.2) provides a useful definition in the introduction to a report on prison regimes:

> *The term ‘regime’ refers in the broadest sense to a system of overall administration. In the institutional setting it is generally taken to apply to the way in which daily life is organised to achieve the basic tasks and objectives. Within the prison setting, the broadest interpretation of regime is the impact of systems of administration upon those who occupy the institution. In common*

usage within the Prison Service regime means daily life for prisoners; in the narrowest sense it is taken to relate only to inmates' occupation….we take regime to mean the impact of systems of administration on all those who live and work in penal establishments (HM Inspectorate of Prisons, 1993).

This definition is notable for acknowledging staff as well as prisoners as being affected by the regime of a prison. There are other explicit explanations of what constitutes a prison regime. Dawes (2009) suggests "a prison regime is the system of government or rules applying within a prison and varies from prison to prison" (p.263). This is a narrower definition, prioritising the importance of rules and perhaps underestimating the less formalised systems of government other sources regard as key to the delivery of the prison. Liebling, Price and Shefer (2011) suggest the daily work of prison officers, routines such as unlocking and locking doors, delivering meals, counting, moving, receiving, discharging and observing prisoners, is both the accomplishment of the regime and only achievable because the regime enables these actions. They argue the smooth delivery of these routines rests on the officers' ability to communicate with and manage prisoners. Crawley (2005a) widens the definition further, to include a prison's timetable, physical layout and activities, as well as it rules and practices. The vagueness of the term 'prison regime' permits very different definitions. Rodriguez (2006) argues for a 'meso' definition, between a macro- and micro-level understanding, which includes processes, structures and vernaculars. Rodriguez regards the parameters of the term as both including dominion in line with the conventional understanding of a discrete area of territory controlled by the ruling order or state, and the Latin concept of dominium as dominion over tangible things, in which prisoners are regarded as the property of the state. He regards this as a critical or radical understanding of the prison regime, as opposed to the more traditional approach usually taken by sociology.

In most prison research, prison regimes are recognised as varying between establishments (HMCIP, 1992, Liebling, Price and Elliot, 1999, Crawley, 2004). Liebling, Price and Elliot equate the regime with how prisoners are 'policed' and observe that "the way in which prisons are 'policed' can vary from 'liberal-permissive' to near 'zero-tolerance' between wings, between establishments and over time" (p.74). The notion that prison regimes vary is supported by Crawley (2004) in her study of prison officers, where she finds many officers feel a liberal regime presents them with more difficulties because when prisoners are out of their cells for longer, relationships between officers and prisoners become more informal. Whilst this research project does not seek to provide a definition of prison regimes, it

will illustrate how the differing regimes in the two prisons studied inform the situation of a dying prisoner.

In order understand the prison regime, it is important to consider its component parts. Liebling, Price and Shefer's (2011) appreciation of a prison regime argues it is how prison officers do their jobs which influences the nature of the prison regime. Other research suggests governors are key to keeping prison regimes functioning (Bryans, 2007). In reviewing the literature on prison regimes, it is therefore useful to include the roles of both of these groups, together with the contribution other staff make to the development and maintenance of prison regimes. In addition, it is important to consider the use of rules, emphasised by Dawes (2009) in his definition of prison regimes, and the commensurate use of discretion, which other studies (Liebling and Arnold, 2004; Liebling, 2000; Hawkins, 1992; Hay and Sparks, 1991) argue is essential to the delivery of a prison regime.

Governors

Governors are seen to 'set the tone' for the prison (Liebling, Price and Shefer, 2011) and to fulfil a variety of management functions, both generic and specific to the prison setting (Bryans, 2007). In this respect, they arguably have a key role in establishing the type of regime that exists within the prison they govern. Despite the changes to prison management that have occurred in recent years, however, their role remains under researched (Bryans 2007), particularly in comparison with prisoners and even prison officers (Crewe, Liebling and Hulley, 2015).

Since the 1980s and the introduction of managerialism within the prison service, the role of the prison governor has changed (Crewe, Liebling and Hulley, 2015). The number of management layers within the prison hierarchy has reduced, and despite resistance to the changes, Liebling, Price and Shefer (2011) argue there has been "a marked improvement in the management of the Prison Service, more visible leadership and a greater willingness by Prison Service senior managers to tackle 'big issues" (p.189). Cheliotis (2008) however, is highly critical of this new managerialism, claiming that by evaluating prisons with reference to measurable targets such as resource allocation or overcrowding, "prisoners are viewed not as coherent subjects, but as aggregates or mere statistical units within impersonal frameworks of policies" (p.247). This new managerialism has, in the view of Cheliotis, increased the hierarchical division of labour within the prison service, introduced competition between prisons through league tables, curtailed the

discretionary powers of governor and introduced key performance indicators with the purpose of controlling front line staff. Bennett (2016) suggests a more subtle approach is required to re-imagine the role of the prison governor, rejecting the extreme stereotypes of the governor as a traditional 'local hero' or as a manager reluctantly constrained by and compliant with trends towards managerialism.

Bryans (2007) characterises prison governors as fulfilling a range of tasks, including taking responsibility for finances, human resources, planning, auditing and incident management. This is in addition to prison-specific functions such as maintaining a secure prison, achieving order, providing positive regimes and regulating the prison environment. Shaping the prison regime is thus only part of their identifiable tasks. Bryans (2007) describes governors as having power delegated to them by the Secretary of State, answering to an area manager, and directly managing a number of functional heads and operational managers who have additional duties. In addition, he portrays them as occupying figurehead roles (Bryans, 2007). This is supported by Crewe et al. (2015) who describe prison governors as having power as symbols, hyper-visible and observed closely by prison staff. In their view, effective governors use the power derived from their role as a figurehead to set boundaries of decency, amongst other expectations. Another important role of prison governors is to model right relationships within the prison which Liebling, Price and Shefer (2011) argue their figurehead status enables them to do through their dealings with individual staff members or prisoners, in full view of others within the establishment (Liebling, Price and Shefer, 2011). Maintaining a perception of fairness is an important part of the governor's role. As Bryans, (2007) says: "A key role for the governor was ensuring that prisoners and staff viewed the operation of the prison as being legitimate, just and fair, and that security, order and regime were held in balance" (p.135).

Prison officers

In recent years, there has begun to be a new academic focus on the role of prison officers. Lerman and Page (2012) suggest that until the 1970s, prison officers were ignored in prison studies, and that it is still not fully understood what shapes their perspectives. Crewe, Bennett and Wahidin (2008) consider prison officers to have not been entirely ignored, but similarly suggest the focus has been on prisoners. Liebling, Price and Shefer (2011) argue the low visibility of the prison officer may contribute to their being overlooked in research. With regard to the gaps in understanding prison officers, Arnold, Liebling and Tait (2007) claim there is little

known about prisoners' views on prison staff and Tait (2008a) suggests current literature misses the welfare responsibilities of prison officer. What research does exist is criticised by Arnold, Liebling and Tait (2007) for "casting them [prison officers] as monolithic, male, power-hungry enforcers of authority" (p.471). However, by 2016, Arnold argues prison officers are no longer neglected by academic research, but that it is still not possible to depict them fully. She suggests further research is needed on "the more intrapersonal and psychological attributes of the prison officer — their self-conception as an officer, their sense of meaning and purpose, their motivations, coping mechanisms, values, stresses and emotions" (p.265).

The importance of the role of prison officers in operationalising the prison regime is not disputed. Prison officers have the most contact with prisoners (Hay and Sparks, 1991) and "play an influential role in the lives of many inmates because of their direct and prolonged interaction" (Farkas, 2000, p.431). Prison officers are the largest group of employees within the prison service (Arnold, 2005) and the main providers of care and supervision to prisoners (Newell, 2002). As Chief Inspector of Prisons, Ann Owers regarded them as key to the delivery of Her Majesty's Chief Inspector of Prisons' four 'tests of a healthy prison' (Owers, 2006). Prison officers make the paramount contribution to the prisoner's experience of imprisonment: "it is in the hands of staff to either aggravate or alleviate the inherent pains of imprisonment" (Hay and Sparks, 1991, p.6). As Crawley (2004) argues, how prison officers regard their work, the prisoners they work with, and their colleagues, has implications for the prison regime and relationships within the prison system. Crewe, Bennett and Wahidin (2008) suggest a further reason why the study of prison officers is necessary: through a refined analysis of staff culture, practices, values and experience it becomes possible to understand what leads to a decent prison regime, and what role the prison officer has in achieving this objective.

Most studies describe the motivations of prison officers for joining the service as mixed (Arnold, 2016; Liebling, Price and Shefer, 2011; Arnold, Liebling and Tait, 2007; Crawley, 2004; Bryans and Jones, 2001). Arnold (2016) suggests people are attracted to becoming prison officers on the recommendation of friends, because of their personal circumstances or a dissatisfaction with their current work, because of an interest in offenders and through economic pragmatism. The salary and possibility of a job for life are amongst the extrinsic motivations identified by Bryans and Jones (2001). Intrinsic motivations include job satisfaction derived from the

variety of the role, from interaction with prisoners and from teamwork (Arnold, 2016). Liebling, Price and Shefer suggest there is a sense of vocation in some prison officers, overlooked in the academic literature. Arnold (2016) finds motivations change over time, with experienced officers becoming less ambitious about the possibility of positively influencing offenders. She finds there is a shift from motivations based on making a difference to a concern for colleagues and a desire to make the work easier (Arnold, 2005). This is summarised by Arnold, Liebling and Tait (2007) who say good officers "reconstruct their sense of 'meaningfulness' in the job and their concept of what it means to 'make a difference'" (p.478).

It is interesting, however, that the training prison officers receive does not necessarily align with their motivations for taking the job. Arnold (2016) finds that in the selection, assessment and recruitment of prison officers, the emphasis is on evaluating their interpersonal, teamwork, leadership and problem solving skills. In contrast, she describes prison officer training as prioritising security supervision and policing functions, with considerable importance being placed on control and restraint techniques. No formal modules address interpersonal skills, or the delivery of care and support to prisoners. As a result of their training and its emphasis on security, Arnold suggests, prison officers develop negative attitudes towards prisoners. They acquire loyalty and solidarity to colleagues, and distrust and cynicism towards prisoners. Similarly, Crawley (2004) describes prison officers' training as fostering a need for detachment in new recruits, with friendliness to prisoners being regarded as a potential security risk.

This mismatch between the skills sought at recruitment and those prioritised through training is indicative of a wider conflict within the role of prison officers, which is a recurring theme in the literature. Thomas (1972) depicts the tension between rehabilitation and security as 'generic' within the English prison system and suggests it originates in the confusion of organisational goals within the twentieth century prison service. It is left, Thomas asserts, to the basic uniformed officer to attempt to resolve this on a daily basis. Thomas argues the prison officer's role does not exist within a vacuum, but within the context of a wider social structure and of the prison service's ongoing development. Hay and Sparks (1991) attribute the conflict within the role of prison officers to trying to address ambitious progressive reforms at a time of shortages and unrest, something which could arguably apply to other timeframes. For Liebling, Price and Shefer (2011), the issue is that "staff work to overall goals that may be in conflict with each other" (p.45) and like Thomas

(1972) they find it is individual prison officers who must reconcile this in specific circumstances. They conclude, however, that the historic role-conflicts experienced by prison officers are lessening. Crawley (2004) suggests there are also conflicts between staff about their roles: “inter-staff conflict as to what the prison officers’ role should consist of, how the job should be done and who should be doing it are often intense” (p.168). This points to a further difficulty, that of defining the role of prison officer.

Crawley (2004) suggests it is not possible to define the role of prison officers, arguing that “compressing the myriad ways in which prison officers think about, feel about and perform their work into a descriptive ‘working personality’ is perhaps merely to construct yet another stereotype” (p.252). Whilst acknowledging different cultures, norms and definitions of the role exist, often within the same prison (Liebling, Price and Shefer, 2011; Crawley, 2004) researchers have attempted to provide a definition of the characteristics and orientations of prison officers. Thomas (1972) perhaps has more confidence in the ability to do this, saying “it will be shown that his role has always been to control and that his success or failure as an officer is measure against his ability to do that” (p.xiv). In contrast, Hay and Sparks (1998) find it harder to define the role of a prison officer because policy makers have avoided doing so, and because “staff in different prisons that we studied tended to construct models of good practice based on personal experience and local tradition” (p.5). This suggests the role of prison officer is itself shaped by the regime of the prison where they work. Crawley (2004) claims that “prison officers are a diverse group who defend distinctly different visions and versions of the prison officer role” (p.xvi). She suggests there is no shared sense of direction amongst prison officers, with a range of approaches to prisoners, but that officers tend to form close relationships with like-minded staff. Again there is a similarity here with other research, including Liebling, Price and Shefer (2011) who suggest “many officers gravitated to a particular wing or section of the prison whose working style suited their own personality” (p.60). What is being described is a tendency for prison officers to work in an area of the prison where the regime suits them.

There is also considerable commonality between authors as to the characteristics required by a ‘good’ prison officer. Arnold (2016) finds the best officers, in the eyes of their colleagues, have honesty, integrity, moral values, composure and empathy. The moral dimension is also emphasised by Hay and Sparks (1991) and Newell (2002), with Hay and Spark finding “officers hold values and precepts which

underpin and serve to legitimise their work" (p.5). Arnold (2016) also finds good prison officers are "resilient, sanguine, tolerant and reliable, vigilant, prudent, perceptive, non-confrontational and non-judgemental (p.273). This list overlaps with the characteristics of role model prison officers identified by Liebling, Price and Shefer (2011) which further includes having known and consistent boundaries, having moral fibre, an awareness of the effect of one's power, an understanding of the painfulness of prison, a professional orientation and an optimistic but realistic outlook. Another similar list is produced by Crawley (2004), again based on peer perception, which includes confidence, powers of persuasion and calmness, being a good communicator and a good team player, knowing when and how to be assertive, being patient, fair, mentally strong and possessing common sense and a sense of humour. Hay and Sparks (1991) list the characteristics needed — tact, humour, insight and compassion — as the ones that will help prison officers establish appropriate relationships with prisoners.

Behind these lists of characteristics lies the question of how prison officers come to possess the necessary attributes. Hay and Sparks (1991) suggest there are two common perceptions; that the role is essentially only common sense, or that it requires a kind of 'alchemy' (p.3). Either of these approaches serves in their opinion to de-intellectualise the role, and has implications for whether prison officers can be formally trained. They use the analogy of a footballer, capable of scoring beautiful goals, but not of explaining how they did it: "prison officers sometimes exercise social skills of great refinement and complexity without dwelling upon or articulating what they are doing" (p.3). Liebling, Price and Shefer (2011) are clear the role of prison officer is a great deal more complicated than just common sense. For them, the key role of a prison officer is that of 'peacekeeper' with the quality of their relationships underpinning every activity they undertake in a typical day. Arnold, Liebling and Tait (2007) recognise no individual can achieve all of these skills and attributes. Instead, they suggest the real skill is in knowing which 'tool' to select for the immediate task. In their view "officers don't have to be good at everything, they need to find their niche, use their strengths and acknowledge their weaknesses" (p.478). These authors also recognise there is more than one way to be good at the job. Arnold (2016) argues the mix of different skills between prison officers is what is important in a well-run prison.

Aside from the characteristics required of prison officers, there is now considerable agreement amongst scholars on the tasks performed by prison officers which deliver

the regime. Whilst Thomas (1972) argues the tasks of prison officers are primarily custodial (checking security measures, locking and unlocking doors), later writers present a different picture. Crawley (2004) shows that much of the work of a prison officer is mundane and domestic in nature, comprising of cleaning, serving meals, doing laundry — tasks traditionally regarded as 'women's work'. She says this work is downplayed by prison officers in their accounts of the jobs: "the contrast between officers 'war stories' and the mundane realities of their everyday lives on the landing is marked" (p.130). This echoes Liebling, Price and Shefer (2011) finding, discussed above in the context of defining prison regimes: "much of their daily work involves the accomplishment of routines: unlocking, delivering meals, counting, moving, receiving, discharging, observing and locking up." (p.78). The care aspect of their tasks is arguably overlooked (Arnold, 2016) and will be discussed further when literature on care in prison culture is reviewed.

Much of how prison officers undertake their role is, Crawley (2004) argues, based on performance. She finds it takes time for a new prison officer to acquire "the walk, the talk, the posture, jargon, mindset, values and beliefs" (p.84) that constitute their working identity, but that as prison officers they manage their performance and control the impression they give to both colleagues and prisoners. Some tasks challenge this. Crawley (2004) finds "officers who chose to work with elderly prisoners are seen as not doing 'proper' prison work because it is seen as too quiet, too predictable and too safe" (p.221). Working with elderly prisoners has implications for their self-identity, their relationships with 'mainstream' colleagues and their interactions with prisoners. When the officers choosing to do this are themselves older, they can, Crawley claims, achieve a strong sense of job satisfaction and may also be excused compliance with organisational norms because of their age and experience. However, Crawley argues, prison officer choosing to work in specialists regimes risk spoiled work identities either from working with despised prisoner groups or from being part of regimes with values which are counter to traditional prison work norms. In these circumstances, officers risk ridicule from their peers and will need to renegotiate their working identities to demonstrate the positive values of their roles. Whilst none of the literature on prison officers discusses their work with dying prisoners, Crawley's (2004) finding illuminates the challenges faced by prison officer choosing to work in specialist roles which could include palliative care.

Other staff

Very little academic research examines the role of staff other than governors and prison officers in determining and maintaining the regime of a prison. This is in keeping with the notion that specialists in the provision of welfare within prisons, such as chaplains, drug specialist, probation officers, workshop instructors and volunteers are ignored in prison studies (Crewe, Bennett and Wahidin, 2008). Prison-based healthcare professionals receive more academic attention (see Maeve and Vaughn, 2001; Norman and Parrish, 1999), although the focus is typically on how the prison regime impacts on the delivery of healthcare, rather than on how the actions of healthcare professionals deliver the prison regime.

Sundt and Cullen (1998) describe prison chaplains in the US as fulfilling multifaceted roles, not confined to religious tasks. Their focus is on supporting the prisoners, not on custodial tasks. Later writers such as Hicks (2012) emphasise the role of prison chaplains in rehabilitation work with prisoners, although in both the US (Hicks, 2012) and the UK (Todd, 2014), this contribution is constrained by security considerations. Both Hicks (2012) and Sundt and Cullen (1998) regard prison chaplains in the US as potential agents of social change and of social control. They occupy the space between prison officers and prisoners (Hicks, 2012; Craig, 2002). Crewe, Warr, Bennett and Smith (2013) describe chaplains, together with education staff, as creating spaces which serve as ‘emotion zones’, where there is relief from the realities of life on the wing. In order to do so, civilian staff “had to play with, subvert or offer alternative displays of authority from those found elsewhere in the prison” (p.69), allowing their authority to be challenged and deliberately differentiating themselves from prison officers. Arguably, Crewe et al. (2013) are describing these staff as creating an alternative regime, deliberately differentiated from the usual prison regime and limited to the location and timing of the class or worship group.

Like the role of prison chaplains, the work of prison nurses is characterised as multi-faceted, although it attracts considerably more academic interest. Norman and Parrish (2002) identify their tasks as including assessing physical, psychological, spiritual, emotional and social needs, transacting care delivery, providing counselling and health education, collaborating with other agencies, clinical decision making, advocacy and rehabilitation. Powell, Harris, Condon and Kemple (2018) provide an alternative exhaustive list of tasks for prison nurses: assessing newly arrived prisoners, prescribing some medication, providing nurse-led triage, seeing

minor injuries and ailments, running nurse-led clinics, making referrals to specialists, providing primary mental health care and trying to encourage healthy living. MacDonald and Fallon (2008) list a range of healthcare staff working in prison settings, including nurses, mental health nurses, doctors, pharmacists, opticians, physiotherapists, occupational therapists, dieticians and health promotion professionals. It is then striking that the literature on prison healthcare staff focuses almost entirely on the working lives and experience of nursing staff. Even when it is acknowledged that they are part of a multi-disciplinary team (Norman and Parrish, 2002), considerably more attention is paid to nurses, and to their relationships with the prison officers in these teams, rather than to the roles of other healthcare professionals. Amongst the nurses, there is, according to Norman and Parrish (2002), a variety of professional backgrounds and no specific prison nursing training.

It is recognised in the existing studies that the work of healthcare staff in prisons is different to the work of their colleagues in other settings because of the prison regime. The prison environment is described as "unique" (Choudry, Armstrong and Dregan, 2017; Thomson and Parrish, 2002) and prison regimes typically regarded as antithetical to healthcare provision. Dhaliwal and Hirst (2016) and Norman and Parrish (2002) suggest there are conflicting ethical and philosophical ideologies between the prison and the other environments in which nurses deliver care such that "the philosophy and regime may mitigate against the provision of high quality healthcare" (Norman and Parrish, 2002, p.18–19). Walsh and Freshwater (2009) go further, claiming there is an inherent conflict in providing care in a secure setting. Providing nursing care in prison is seen as different from other settings because of the strict boundaries of the prison regime which limit how nurses can care (Weiskopf, 2005) and the necessity of organising treatments around time-focussed prison regimes (Norman and Parrish, 2002). It is suggested that nurses need to comply, conform and socialise to prison life, to adapt to the way security needs govern prison life in order to demonstrate their credibility to clients and employees, but this may present ethical dilemmas (Norman and Parrish, 2002).

A number of studies suggest nurses require specific skills in order to work effectively in the prison setting (Powell et al., 2018; Dhaliwal and Hirst, 2016; Walsh and Freshwater, 2009; Weiskopf, 2005; Norman and Parrish, 2002). The result of developing the skills suitable to work as a prison nurse leads, Choudry, Armstrong and Dregan (2017) suggest, to a change in nurses' professional identity as they become more positive and confident in their role over time. There is strong

unanimity about the main challenges facing prison healthcare staff. Negotiating boundaries between custody and caring is identified in many studies as the main problem raised by healthcare staff (Powell et al., 2018; Dhaliwal and Hirst, 2016; Weiskopf, 2005) with the same problem being sometimes framed as negotiating the boundary between care and 'control' (Foster, Bell and Jayasinge, 2013). Several studies emphasise the importance of healthcare staff finding a 'balance' between their duty to care and the security culture of the prison (Foster, Bell and Jayasinge, 2013; Walsh, Freshwater and Fisher, 2012; Weiskopf, 2005; Norman and Parrish, 2002). Security is always on the minds of nurses (Weiskopf, 2005). Correctional priorities are seen by nurses and visiting healthcare professionals to dominate nursing priorities (Dhaliwal and Hirst, 2016; Foster, Bell and Jayasinge, 2013) such that the culture of prison in terms of order, control and discipline overrides the caring perspectives of healthcare staff (Powell et al 2018) and security considerations are placed above the healthcare of prisoners (Choudry, Armstrong and Dregan 2017).

Rules and the use of discretion

Discretion in the legal system is, Hawkins (1992) contends, "inevitable because the translation of rule into action, the process by which abstraction becomes actuality, involves people in interpretation and choice" (p.11). With reference to the prison service, Liebling and Arnold (2004) argue "discretion is inevitable where there are rules (and there are too many rules to follow in prison life to make it through the day)" (p.266). Others (Bennett, 2016; Crewe, 2008; Cheliotis, 2008) argue increasing managerialism within the prison service has reduced the room for discretion, but it is still, according to Liebling (2000) and Bryans and Jones (2001) used a great deal by prison officers and essential to prison managers (Bennett, 2016). Everyday examples include the speed at which prison officers chose to answer cell bells and how they address prisoners (Bryans and Jones, 2001), which rules they ignore or enforce (Liebling and Arnold, 2004; Bryans and Jones, 2001) or what they include or omit in a report which may influence a prisoner's sentence (Crewe, 2011; Bryans and Jones, 2001). There is a link between the use of discretion and staff-prisoner relationships (discussed below), with Liebling (2008) suggesting the rules are relied on when relationships are not working; discretion is used when relationships are good.

One of the dominant themes emerging from the research of Crewe, Liebling and Hulley (2015) is that although governors feel less trusted as result of the reduced scope for discretion inherent in managerialism "prison governors cannot do their job

by the book and good governors do not try" (p.7). Instead, the authors suggest, effective governors are willing to sacrifice achieving performance targets in order to provide more moral outcomes. Bennett (2016) supports this, suggesting governors use their discretion for humanitarian reasons, to provide what is seen as fair, but do so with an awareness of the impact this will have on the prison.

There is considerable consensus about why discretion is needed: because rules cannot exist for every occasion (Hawkins; 1992; Hay and Sparks, 1991) and because where they do exist, they will at times be inadequate for the real situation. As Liebling and Arnold (2004) argue, "there is a tension between any detached application of the rules and the resolution of real, complex moral and social problems" (p.266). Discretion is needed because, Liebling (2000) suggests, 'particular' situations cannot be adequately resolved by 'general' rules. In this way, 'rule-failure' discretion (Schneider, 1992) is prominent in prisons. As Liebling (2000) argues "in the absence of any clearly articulated organisational principle, good staff developed or applied their own" (p.346). Discretion can also serve to mould prisoner or staff behaviour; "as a means of rewarding and punishing so as to establish, reinforce and embed norms" (Bennett, 2016, p.143). The Incentives and Earned Privileges scheme is used by Liebling (2008) and Crewe (2008) as an example of this in practice. In using discretion, Liebling (2000) suggests "there needs to be a link between 'what works' for today, 'what works' for tomorrow or the end of the week and 'what is fair'" (p.340).

A number of studies link discretion to personal power. This is reminiscent of Scheider's (1992) description of 'khadi discretion': that based on an individual's special qualities. Bennett (2016) gives as an example of this a Senior Officer being asked to give permission to a prisoner to make a phone call on compassionate grounds, for which there are no guidelines, arguing "discretion in these cases was informed by the values of both compassion and order or security" (p.142). Whilst discretion gives prison managers a form of agency and provides a means by which they "brought their role to life" (Bennett, 2016, p.147) the dangers of 'khadi discretion' are also clear. Liebling (2000) suggests that in some circumstances, prison officers may use the permission they have to act with discretion as a means to reinforce their authority. Whilst Liebling (2000) regards the use of discretion as part of a prison officers 'peace-keeping' role, Scott (2006) disagrees, saying "the literature overwhelmingly indicates that prison officers do not transcend the rule of law to enforce peace, but rather to maintain the power relations of the existing penal

order and their asymmetrical status" (p.19). Liebling and Arnold (2004) do see the weaknesses in discretion, saying too much discretion can become discriminatory. Similarly, Crewe (2011) is critical of the use of discretion in systems such as IEP for its lack of transparency.

Whilst the literature does not explicitly address the use of discretion in relation to the prison regime experienced by dying prisoners, Crawley (2005b) does consider how it is used in work with elderly and frail prisoners. She is critical of the lack of use of discretion, and particularly of the "sameness principle" (p.356) by which prison officers find moral justification for treating all prisoners the same, regardless of their needs. She describes the negative impact of this: "simply stated, the more needy, more dependant and more compliant the prisoner group in question, the easier it becomes for prison staff to find recourse within the sameness principle for conferring or denying benefits and burdens arbitrarily" (p.356). As part of her study, Crawley (2005b) found discretion was being used to assist elderly prisoners, but that these instances ran counter to the prison's tendency to flatten difference.

2.4 Prison culture and relationships

This section will consider prison culture and relationships as they relate to the research questions. In particular, it will focus on the literature surrounding occupational cultures for those staff likely to have contact with dying prisoners, as background to later analysis of data to address the research question about what determines responses to dying prisoners. Next, it will review the literature on staff-prisoner relationships, which is relevant to both research questions, before addressing existing literature on care within prison culture. Finally, the limited literature on the role of prisoner-carers will be considered, highlighting both an aspect of care within prison culture and the nature of some prisoner-prisoner relationships.

Studies of prisons assume a separate and identifiable culture exists within prisons: "prisons are special communities (but communities nevertheless) which exist at once outside and inside the social community" (Liebling and Arnold, 2004, p.462). Prison culture in the UK is regarded as under-researched (Liebling 2008) although its considerable impact on prison life is recognised as an argument for further academic attention (Arnold, Liebling and Tait, 2007).

It is acknowledged separate prisons have their own cultures (Drake, 2011; Liebling Price and Shefer, 2011; Liebling, 2008; Arnold, Liebling and Tait, 2007; Leggett,

2002) and that different cultures may exist within a prison (Leggett, 2002) as well as between officers and other staff and prisoners (Kauffman, 1988). Liebling (2008) argues cultures are linked to the goals of the establishment. Leggett (2002) identifies a number of further determinants of a prison's culture, including its history, current condition and management style. The extent to which individuals follow the dominant culture within the prison may also vary (Arnold, 2016).

Where UK studies exist (Arnold, Liebling and Tait, 2007; Crawley and Crawley, 2008, Liebling, 2008) they often focus on prison officer culture, rather than the culture of the prison as a whole. Crewe (2009) addresses US twentieth-century prison research which debated how far prisoner culture was derived from the deprivations of imprisonment (Sykes, 1958) or imported from outside criminal culture (Irwin and Cressey, 1962) to produce an ethnography of HMP Wellingborough which seeks to show how importation and deprivation models combine to produce prison cultures. He finds prisoners' social relationships and everyday culture are influenced by three main factors; the prison's inherent structural imperatives, the culture, function and policies of the particular prison and the ideologies and inclinations of the prisoners before imprisonment. As with earlier prison studies (see Giallombardo, 1966; Sykes, 1958; Clemmer, 1940; and many others), Crewe (2009) produces a typology of prisoners as a tool for providing a description of social life within the prison. However, he concludes: "one of the clear findings of this study is that there is no such thing as a typical prisoner or a single 'prison culture'" (p.154). He portrays prisoners as distinguishing between their relationships with their peers as 'real friends', 'prison friends' and 'associates'. In Crewe's (2009) research, the strongest basis for a relationship with another prisoner is a shared home background, with shared race and ethnicity also being significant. Crewe describes the difficulties of prisoners in trusting each other, and suggests "for the majority of prisoners, the prison was a site of inauthenticity and a place where social conditions inhibited the formation of friendship" (p.322). He finds friendship cliques were typically small, and on a wing a fifth of prisoners may choose to be solitary.

Occupational cultures in prison

Given their predominance in terms of numbers and contact with prisoners, considering prison officers' occupational culture is important to understanding prisons. In the existing literature, prison officer culture is defined as being based on a shared set of assumptions, values, beliefs and attitudes which shape how prison officers respond to each other, prisoners, managers and the outside world, as well

as which skills are prized and which roles are sought after (Liebling, 2008). The occupational culture of prison officers determines what language is used and the 'craft rules' of how the job is done, a term used repeatedly by Liebling (Liebling Price and Shefer, 2011; Liebling, 2008; Arnold, Liebling and Tait, 2007). It is learned through occupational socialisation (Arnold, 2016) and focussed around an influential leader, not necessarily someone in a formal position of authority (Liebling, 2008).

There is remarkable similarity in how authors describe prison officer culture. Crawley and Crawley (2008) characterise its key features as solidarity with colleagues, suspicion and cynicism towards others, and an emphasis on physical courage. Liebling (2008) and Arnold, Liebling and Tait (2007) list a strong sense of camaraderie, wariness towards outsiders, a sense of public mission, cynicism and pessimism, machismo, pragmatism and a sense of separation from managers as principle features. These lists owe much to the work of Kauffman (1998) who identified nine cultural norms in her study of a US prison, many based on a sense of duty towards colleagues in contrast to other groups within the prison. Liebling (2008) questions how far these norms apply to UK prisons, but accepts there is considerable overlap.

Prison officers' occupational culture can vary within and between prisons. Drake (2011) in her study of high security prisons in the UK, finds prison officers come to see the prisoners they work with as very violent offenders, even though not all of them are in the highest security risk category. This in turn influences the culture of the prison to the extent that a "'Cold War' atmosphere prevails, complete with espionage, other forms of intelligence gathering, tactical and contingency planning, and even a degree of propaganda" (p.375). In contrast, Crewe (2009) describes HMP Wellingborough, a category C prison, as having a 'family' feel, with officers maintaining relatively relaxed relations with prisoners.

A shared prison officer culture serves a number of purposes for staff, but can be detrimental to prisoners. Whilst Arnold (2016) argues the sense of solidarity between prison staff is less marked than in the past, with prison officers being more individualised and holding different conceptions of their job, she describes prison officers' occupational culture as still helping them survive the demands of the job. A strong prison officer culture can lead to good relations between staff, although perversely it also tends to undermine relations with managers (Liebling, 2008). It may also be damaging to individuals who do not conform. For example, officers who would prefer to behave compassionately in a machismo culture may experience

pressure to behave differently (Crawley and Crawley, 2008). As Liebling, Price and Shefer (2011) say, “Prison staff cultures can be healthy or unhealthy, or simply a reflection of current ‘biographical’ developments in an establishment at a particular time” (p.181). For prisoners, however, a number of negative effects are attributed to what is defined as a ‘traditional’ prison staff culture. Liebling (2008) suggests strong traditional prison staff cultures tend to be associated with more negative prisoner perceptions of relationships with staff, and fairness, care and safety, and with an increase in prisoner distress. The interconnection of the prison community is highlighted by Liebling’s argument that ‘traditional’ culture may be stronger if the prison officers feel themselves to be undervalued or distrusted by their managers.

The literature on prison governors suggest a less consistent occupational culture. Bennett (2016), Bryans, (2007) and Crewe and Liebling (2015) suggest prison governors bring their own personality and values to the role and develop their own working style. Bryans (2007) identifies a range of instrumental and non-instrumental motivations for becoming a prison governor, with most governors joining the prison service because of an interest in the work and a desire for a socially useful job. He suggests management styles may vary from autocratic to more ‘power-sharing approaches’ (p.189), with some governors being more ‘hands-on’ than others. His interviews with prison governors suggest some take a managerial perspective, devoid of a moral mission, whilst others are more actuarial, seeing the bigger picture rather than the individual (as Cheliotis, 2008, claims) or try simply to reduce the negative effects on prisoners of their imprisonment. Bryans (2007) however finds the majority of prison governors believe prisoners can change, or rather need to decide and be motivated to change. It is these values, Bryans (2007) argues, that motivate them in their roles as governors. He recognises, however, that how a Governor spends their time on a daily basis may be determined as much by the characteristics of the prison. Bryans suggest a typology of prison governors including: “general managers”, “chief officers”, “liberal idealists” and “conforming mavericks” (p.159). Bennett (2016) offers an alternative model for governors’ orientations: professionalism, reform, rehabilitation and humane treatment, and punishment and security. Each of these authors rightly recognise the limitations of such typologies.

In the view of Crewe and Liebling (2015), good governors take seriously the emotional dimension of their work, and are able to express their emotions. This is despite their finding that prison service culture and the culture amongst governors is uncomfortable in acknowledging the existence of an emotional dimension to prison

work. This prison governor culture is represented as macho: “managing from the pub and the curry house” (Crewe and Liebling, 2015, p6) and thus marginalising to certain types of people. Unsurprisingly the authors point out women are not well represented amongst senior prison governors. Cultures do change; Bennett (2016) suggests one of the impacts of the trend towards managerialism has been that “machismo has largely been transferred from physical confrontation to the attainment of targets” (p.132).

A number of academics address the subject of healthcare staff working in the prison setting, described by Burles, Peternelj-Taylor and Holtslander (2016) as “at the shifting interface of the criminal justice system and the Health Care system” (p.99). With regard to the occupational culture of healthcare staff, one of the key concerns of the existing literature is how this differs from other professional groups within the prison. Walsh, Freshwater and Fisher (2012) claim there is felt by nursing staff to be a professional divide in terms of underpinning philosophies between prison officers and nursing staff. Several studies emphasise the importance of healthcare staff finding a ‘balance’ between their duty to care and the security culture of the prison (Foster, Bell and Jayasinge, 2013; Weiskopf, 2005; Norman and Parrish, 2002). Weiskopf, (2005) contends that some nurses in her study saw caring for prisoners as a constant fight with custody officers, whilst others had close relationships with officers which could make caring for patients harder since they had also to demonstrate collegiality with correctional officers. Caring, as experienced by prison nurses, thus becomes an attempt to negotiate boundaries between cultures of custody and caring (Weiskopf, 2005). When prison officers failed to understand, respect, or accept the role of prison nurse, Choudry, Armstrong and Dregan (2017) argue, nurses experienced decreased autonomy and increased frustration. In contrast, Foster, Bell and Jayasinge (2013) suggest officers and nurses working in the prison inpatient wing they studied reported working in tandem, switching between collaboration and cooperation as needed and Powell et al. (2018) find prison nurses felt they could not operate without the support and cooperation of officers.

Interestingly, studies find relationships with other nursing staff in the prison could also be problematic. Weiskopf (2005) maintains that the non-caring attitudes of nursing colleagues was a major source of stress and negativism for some prison healthcare staff. Similarly, Walsh (2009) finds working with nurses whose practice was below standard led to anxiety amongst their colleagues. Maeve and Vaughn

(2001) depict prisons as potentially attracting healthcare staff who wish to control and punish prisoners, rather than provide the best possible healthcare, arguing working to provide healthcare in a prison is not a highly prized job. Norman and Parrish (2002) are clearly aware of this danger too when they warn that nurses need to remember that exclusion from society is the punishment and that professionalism must be maintained despite any personal opinions or difficulties in not showing disapproval towards the prisoner.

A number of studies examine the impact on nurses of working in prison healthcare, with Walsh (2009) in particular discussing the emotional labour necessitated by the role. She suggests that for prison nurses, an emotional dissonance arises from their attempts to reconcile the custody discourse of the prison with the dominant care discourse in nursing. She asserts there are many examples of prison nurses displaying empathy and confidence they do not feel, and hiding feelings of anger and disgust. Walsh and Freshwater (2009) find the emotional labour involved in nursing in prison is significant and can lead to a state of discomfort and tension which affects the wellbeing of nurses and therefore needs to be addressed. For Choudry, Armstrong and Dregan (2017) there is a danger prison nurses will experience cognitive dissonance, where their self-identity and professional identity as nurses become misaligned as result of working in prison, leading them to question their professional identity and choice. Other studies focus on recurring feelings of frustration for prison nurses, arising from the conflict they experience between custody and caring. Powell et al. (2018) identify this as the main reason for is increased frustration and stress among nurses trying to deliver healthcare in prison. Similarly, Weiskopf (2005) finds the nurses she interviewed felt frustration custodial settings have rules that affect nursing, particularly with regard to not touching prisoners and not disclosing personal information.

It is suggested that the job changes prison nurses, making them more security aware and changing their nursing behaviour as a result (Foster, Bell and Jayasinge, 2013; Walsh, 2009; Thomson and Parrish, 2002). The tendency identified is that of accepting the custodial agenda, becoming part of prison officer culture (Foster, Bell and Jayasinge, 2013), and suppressing the emotional side which makes nurses in the prison setting more vulnerable to manipulation but which also enable the qualities of sympathy, empathy and care associated with nursing (Walsh, 2009). Thomson and Parrish (2002) suggest: “some nurses may have been subject to peer

pressure for so long that they are unaware how far they have moved from caring practices and philosophies" (p.46).

Staff-prisoner relationships

The Home Office statement that "relations between staff and prisoners are at the heart of the whole prison system" (Control Review Committee, 1984, para 16) is one widely accepted in studies of relationships between prison staff and prisoners in the UK. There is no dispute that such relationships are crucial to the functioning of the prison. Liebling, Price and Elliot, (1999) explain, "what 'goes on' in prisons goes on primarily through relationships" (p.72) and that "relationships matter because they influence action. They frame, inform, constrain and facilitate staff and prisoner behaviour" (Liebling, Price and Elliot, 1999, p.77). Writing in 1999, they suggested there were few studies offering a satisfactory analysis of staff-prisoner relationships. This gap has since been addressed, by them and other authors, but the importance of staff-prisoner relationships in the achievement of the prison continues to be recognised. In Crewe's (2011) view, the prison service in England and Wales regards staff-prisoner relationships as central to ensuring decent, stable regimes and the rehabilitation of offenders. He argues these relationships are generally more positive in England and Wales than in other jurisdictions. Echoing this, Liebling, Price and Shefer, (2011) suggest in the British tradition of prison management, staff-prisoner relationships are the 'glue' holding the prison together. Similarly, Crawley (2004) finds in her study of the work of prison officers a consensus that control and order in the prison are best achieved through relationships. The influence of good relationships is such that Liebling, Price and Shefer, (2011) suggest "if officers treat prisoners fairly, prisoner will generally consider the prison regime to be fair as a whole" (p.105).

There is a certain inevitably to the existence of at least some form of relationship between prison officers, as Arnold (2016) argues: "as the two ever present groups within a prison, and those who have the most frequent contact, a relationship — whether good or bad — will exist in some form between uniformed staff and prisoners" (p.267). Liebling, Price and Elliot (1999) attempt a definition of 'relationship' in the context of the prison: "we mean (something like) sustained periods of interaction, including interaction of a non-rule enforcing — or rule-resisting — nature" (p.72). What is less clear is what constitutes the appropriate relationship between staff and prisoners. It is recognised (Crawley, 2004; Liebling, Price and Elliot, 1999) that staff-prisoner relationships are complex. Liebling, Price

and Elliot (1999) suggest key characteristics of staff-prisoner relationships which continue to have currency in prison studies. They claim "there is a flow of interaction and dependence in two directions, although in the coercive environment of the prison, the relationship is invested with an unusual amount of power (the ability of one party to influence or determine the behaviour of another party)" (p.71) but this power is mostly 'held in reserve'. The idea that prison officers underuse their power is reiterated in later work (Liebling, Price and Shefer, 2011) and the asymmetric nature of power inherent in the staff-prisoner relationship reinforced by other scholars, (see Scott, 2008; Drake, 2008; Newell, 2002).

Liebling, Price and Elliot (1999) find: "the sort of relationships staff tried to cultivate with prisoners were — at their best — fair, honest and good humoured" (p.84). Good staff-prisoner relationships did not involve the prison officer 'giving in' to prisoners, but instead illustrate the complexity involved, with staff needed to demonstrate both consistency and a degree of flexibility. Crawley (2004) suggests that: "the 'trick' was to develop a relationship whereby staff and prisoners could recognise each other's predicament and 'rub along' on a day to day basis with minimal friction" (p.108). Relationships between staff and prisoners in long-term prisons are recognised as having a different quality. Crawley (2004) finds officers in long-term prison have more sustained contact with prisoners and the prisoners held there tend subsequently to be more informal and familiar in the manner of their interactions with uniformed staff. She suggests prisoners may find they have things in common with officers over long periods of knowing each other. The importance of staff-prisoner relationships is heightened by the context of the long-term maximum security prison, Liebling, Price and Elliot (1999) suggest.

One of the difficulties faced by staff is that of establishing the 'boundary' in their relationships with prisoners. Liebling et al. (2011) suggest prison officers experience a lack of clarity about the 'right' relationship with prisoners. Liebling, Price and Shefer (2011) and Crawley (2004) find that officers talk about the 'boundary' or 'drawing a line' but that there are discrepancies and difficulties in defining where this should be. Liebling, Price and Elliot (1999) give specific examples of some activities where this becomes relevant, identifying disagreements between staff as to whether it is appropriate to play pool with a prisoner, to offer them a biscuit or to accept a cooked meal from them. Whilst it is hard for staff to articulate where the boundary should be, Liebling, Price and Elliot (1999) conclude staff accept their relationships with prisoners do need policing. Crawley (2004) illustrates this difficulty when she

describes how some officers in her study admitted that in other circumstances, they would most likely be friends with prisoners.

A number of factors are found to influence the nature of staff-prisoner relationships. Crawley (2004) suggests that whether prison officers can identify with prisoners, in terms of finding shared values and interests, depends on the kind of the prison, the age and background of the prisoner and to a lesser extent the offence, as well as the staff member's prior work experience and the occupational culture of the prison. Newell (2002) shares Tait's (2012) analysis that good relationships between staff and prisoner involve the staff treating the prisoner as morally equivalent to them. He claims relationships are based on the prison officers' understanding, awareness, and sensitivity towards the prisoner and rely on a respect for the personhood of the prisoner, irrespective of their status, value or behaviour. Without this respect, he argues prison officers cannot provide supervision and care to prisoners. Humour can also serve a function in building relationships. Nielson (2011) suggests its use facilitates social spaces where staff and prisoners can relate as equals and helps avoid and diffuse conflicts and smooth interactions. She suggests humour functions as a "transformative and dynamic device" (p.520).

Several studies recognise, as Crawley does, that the degree of rapport between staff and prisoners varies between prisons and between wings. This follows Liebling, Price and Elliot's (1999) finding there are different types of relationship in different parts of prison, with staff employing different styles of working and using different amounts of power. Variations in staff-prisoner relations are also linked to occupational culture, which similarly varies between locations. Liebling, Price and Shefer (2011) suggest some prison officers orientate towards imposing the rules, whilst others have a human-service orientation, which influences the relationships they develop with prisoners. They find the amount of staff-prisoner interaction depends on the roles of officers and the prisoner. On smaller units, it can be easier for staff and prisoners to build relationships. Tait (2012) give the example of workshops, healthcare centres and Segregation centres, where prisoners' identities as individuals, as someone who works, is unwell or is disruptive, are foregrounded. This echoes the manner in which prisoners build relationships with non-uniformed staff, discussed below. Similarly, she finds prisoners in roles of responsibility which bring them into regular contact with staff, such as cleaners or Listeners (prisoner-volunteers trained and supported by the Samaritans), get to know prison officers on a different basis.

Staff-prisoner relationships are described as fulfilling a variety of purposes. Arnold (2016) suggests staff-prisoner relationships are instrumental and procedural, serving the need of the prison to ensure security. Other authors similarly suggest staff-prisoner relationships are important because they maintain good supervision and control (Newell, 2002) and because it is relationships, not the rigid application of rules that can do this (Drake, 2008). Indeed, Drake argues, “staff-prisoner relationships have become another mechanism of control rather than the ‘heart of the whole prison system’ (Drake, 2008, p.164). Similarly, Crewe (2011) suggests the changing nature of prison has meant “the reduction in social distance between prisoners and uniformed staff has been achieved, to some degree, through mutual compulsion” (p.457). He deduces officers mix more with prisoners because it is now required of them in order to provide ‘dynamic security’, and prisoners engage with officers because it will positively influence their Incentives and Earned Privileges. He argues the relationship is therefore artificial “the outcome of expediency and self-interest as much as genuine engagement” (Crewe, 2011, p.347). In contrast, for Hobbs and Dear (2000) the importance of staff-prisoner relationships is that they facilitate prisoner well-being, with closer relations between staff and prisoners enabling staff to be more aware of changes over time in a prisoner’s behaviour, and to identify when a prisoner needs support. They suggest the pre-existence of a trusting relationship should enable prisoners to initiate interactions with staff in order to seek help.

The attitudes of prisoners towards their relationships with staff have changed over time. Cohen and Taylor, writing in 1972, find that prisoners resented all authority and conceived of staff in negative terms because they represented authority. Whilst the prisoners in their study would credit some status and intelligence to the assistant governors they met, they regarded officers as unintelligent, callous and spiteful. Cohen and Taylor portray a “them and us” culture not dissimilar to earlier studies of US prisons (Sykes, 1958). More recently, Crewe (2011) reports the old inmate codes still haunt some prisoners, who find it hard to trust officers. His 2009 ethnography of HMP Wellingborough found prisoner orientations to staff vary. Whilst prisoners in his study rarely sided with officers against other prisoners in public, many were bemused by the idea that officers should be seen as ‘the enemy’ and clear there were always some good officers. Tait (2012) describes prisoners as unwilling to seek help from officers in case it gave the officer power over them. Even those prisoners willing to build relationships, Crewe (2011) suggests, find it confusing when staff who are friendly towards them write negative comments on

their file. This echoes Cohen and Taylor's (1972) finding that prisoners dislike the hypocrisy they perceive when officers present a soft façade, but later reveal a hard approach to prisoners. Some prisoners do take a different approach and Crawley (2004) finds in her study that certain officers were liked by prisoners, who understood them as just doing their jobs. Differences exist in the attitude of prisoners in privately run and public sector prisons towards staff. Crewe et al. (2015) argue the prisoners in the private prisons in their study were less likely to report feeling staff were morally judging them, whereas staff in public prisons were perceived by prisoners as having a more punitive and cynical attitude towards them. However, whilst prisoners in private prisons complained less about staff attitudes, they complained more about staff behaviour, finding that officers were less able to help sort out their problems. Prisoners wanted staff to fulfil the role as figures of authority, and Crewe et al. (2015) suggest in private prisons, the inability of officers to do this led to prisoner anxiety.

Staff attitudes towards their relationships with prisoners also display a variety of approaches. Crawley (2004) describes officers as using negative metaphors and stereotypes when they discuss prisoners, terms such as 'scum' or 'animal', but also finds that "some officers do admit to liking certain prisoners and to being sympathetic to their feelings of frustration, anxiety and regret" (p.210). She recounts some staff as feeling their managers care more about the prisoners than them, and that prisoners don't appreciate the efforts of staff on their behalf. This is echoed by Crewe (2009). Similarly, Liebling, Price and Shefer (2011) suggest officers do not expect to be treated fairly by prisoners. Scott (2008) writing about the possibility of staff mitigating or exacerbating the pains of imprisonment, argues whilst some officers actively seek to alleviate prisoners' pain, others fail to acknowledge their suffering. In contrast, Liebling, Price and Shefer (2011) find prison officers work with "the worst and most difficult aspects of human spirit, head on. In this sense they could be more liberal, accepting and honest in their practical and daily encounters with prisoners than any of their critics" (p.103).

Although there has clearly been considerable academic attention paid to staff-prisoner relationships since Liebling, Price and Elliot claimed in 1999 that researchers overlooked them, it is striking that this attention has almost all effectively focussed on the relationship between prison officers and prisoners, rather than a more general definition of 'staff'. In one of the few studies considering the relationship between prisoners and prison staff in other roles, Crewe et al. (2013)

outline how staff in prison education departments and prison chaplains relate differently to prisoners, cultivating a different sort of relationship that is based in a different philosophy of the self. In an echo of the relationships that can form between officers and prisoners in smaller units, Crewe et al. (2013) find prisoners in education departments and prison chapels are treated as students, worshippers or workers and addressed as individuals. In creating these relationships, non-uniformed staff, Crewe et al. (2013) suggest, are offering different displays of authority from those found amongst officers. Instead, their relationships with prisoners celebrate success, reinforce positive aspirations, allow authority to be challenged, instruct rather than order and make clear an interest in the personal advancement of the prisoner and a concern for their future that is often missing on the wings.

Bennett (2016) discusses the relationship between prison managers and prisoners, finding managers have a less direct role in prisoners' lives and that a greater social distance exists. He suggests managers often see prisoners through a "prism of managerialism" (p.66), focussing on their influence and effects on performance measures, rather than seeing them as people with feelings and agency. Bennett finds the role of the manager could also reinforce the asymmetric nature of the relationships between officers and prisoners, with some managers keen to reduce the social distance between themselves and staff by being seen to support officers in preference to prisoners.

With regard to prison healthcare staff, a number of studies suggest one of the most dominant features in nurses' relationships with prisoners is the nurses' need to avoid being manipulated by prisoners in their care. Prisoner-patients' manipulative behaviour is reported as presenting challenges designed to compromise or undermine the essence of nursing care (Choudry, Armstrong and Dregan 2017; Norman and Parrish, 2002), with Weiskopf (2005), MacDonald and Fallon, (2008), Walsh and Freshwater (2009) and Foster, Bell and Jayasinge, (2013) all suggesting prison nurses need to be alert to the danger of being manipulated by prisoners. Consequently, Norman and Parrish, (2002) argue prison nursing is an area where nurse-patient relationships and boundaries are of paramount importance. Studies also acknowledge nurses may struggle to feel compassion in their relationships with prisoners, since prisoners have committed crimes against the society of which nurses are a part (Weiskopf, 2005).

Care in prison culture

Care in prison is typically discussed in the existing literature in a more general context than the care of terminally or seriously ill prisoners, although this suggests care in its broadest sense is a feature of prison culture. Tait (2011) argues there is a lack of understanding of what 'care' means in prison. In her research, she interviewed prisoners to find their definition of care, based on their experiences of prison officers they regarded as showing a caring attitude towards them. In this context, caring interactions were those based on respect, fairness and sociability, where prison officers demonstrated their care for prisoners by taking time to listen and by providing practical help. Tait uses her definition of care to provide a typology of five prison officers' approaches to care. Tait's true carer is confident, secure and highly engaged in their caring role and identified by prisoners as caring. The prison officer who is a limited carer has sympathy for the prisoner, but follows bureaucratic rules in how they care. The 'old school' prison officer provides limited emotional support, regards 'care' as a loaded term but is paternal and protective. The conflicted carer conflates care with control and offers conditional care to 'deserving' prisoners. Lastly, the damaged carer used to care, but no longer does, often as the result of a traumatic incident or a lack of management support. Key to this, Tait (2011) argues, is how prison officers view prisoners. She later suggests that care is found in staff-prisoner relationships, describing how interviewed prisoners in her study experienced care as part of their relationship with staff, both as an isolated experience and as something that was unexceptional and part of day to day life. Such relationships had a particular quality: "Caring officers treated prisoners as if they were of equal moral worth. They spoke to prisoners with respect and empathised with prisoners' situations" (Tait, 2012, p.19).

This day-to-day care is very different from the caring Crawley (2005b) describes as needed by elderly prisoners. Caring for prisoners is also discussed by Crawley (2004) in the context of expressing sympathy. Whilst prison officer culture does not forbid expressions of sympathy, they are expected to fit within organisational norms, in which sympathy is more likely to be expressed to a cooperative prisoner than a disruptive one, and not in the hearing of other officers. Kindness to prisoners can be seen as weakness, especially in the context of a perceived conflict between discipline and care (Crawley, 2004). For Arnold (2016) there is a close link in prison officers' minds between security and care, with the provision of a safe environment being associated with meeting a duty of care. Here, however, "it is the way the officers feel they 'look after' and care *for* prisoners (not *about* them) and treat them

with humanity” (p.271). Arnold (2016) argues prison officers are trained to care for, not care about prisoners.

Gender is also seen to be relevant to the care provided by prison officers. In HMP Leeds, one of the fieldwork sites for this research, Tait (2008b) finds female prison officers were steered towards roles requiring caring skills, such as assessing prisoners’ suicide and self-harm risks and committees on ‘softer’ issues such as race and equality. Consequently, they performed the bulk of such ‘care’ work. Bruhn (2013) depicts everyone in a prison, staff and prisoners alike, as regarding women as having special abilities to handle deep or difficult emotions, and to have particular skills as listeners. This is supported by Crewe (2006) who reports male prisoners find it easier to show their emotions to female prison officers. Tait (2008b) whilst maintaining the “prison culture may be more important than gender in shaping officer experience” (p.65) acknowledges gender does become a salient issue in some aspects of the prison officer’s role, especially when working with prisoners who are extremely vulnerable. The examples she gives include self-harm, “where a particularly quality of care was needed” (p.65). The question of how approaches to care in general relate to the care prison officers might provide to dying prisoners is yet to be addressed by academic studies.

Prisoner-carers

Despite the existence in many UK prisons of prisoners employed as carers for their peers, very little academic research within the UK has considered their motivations, training or tasks, or looked at the impact their work with frail and dying prisoners has on them as individuals or the prison more generally. However, a small number of studies do exist of prisoner-carers in the US, including those working as inmate-volunteers in prison hospices. The usefulness of these is limited by the significant differences between the roles of prisoners working as carers in the US and the UK. Within US prison hospices, inmate-volunteers provide a variety of services to dying prisoners, including assisting with personal care such as toileting and skin care, providing companionship and offering religious fellowship. They also hold a vigil at the bed of a prisoner close to death and provide post-mortem care for the body, washing and dressing it ready for disposal. (Supiano, Cloyes and Berry, 2014; Loeb, Hollenbeak, Penrod, Smith, Kitt-Lewis and Crouse, 2013). Supiano, Cloyes and Berry (2014) claim they “represent an unusual hybrid between the community volunteer, nurse assistants and family caregivers found outside the prison” (p.82). In a study in the UK, peer support for frail prisoners at HMP Wakefield, HMP Leyhill,

HMP Hull, HMP Isle of Wight and HMP Whatton instead involved wheelchair pushing, cell cleaning and collecting meals and laundry (Moll, 2013).

The motivations for inmate-carers in US prisons have been explored in a number of studies (Supiano et al., 2014; Cloyes, Rosenkranz, Wold, Berry and Supiano, 2013; Loeb et al., 2013). The majority of inmate-carers in the US are volunteers and their roles in the prison hospice will not be included in any considerations of their entitlement for parole. Instead, their motivations are categorised by studies as including a desire to make the experience of dying in prison better (Supiano et al., 2014; Cloyes et al., 2013) to give something back (Cloyes et al., 2013; Loeb et al., 2013) or 'pay it forward', (Cloyes et al., 2013). Motivations are also regarded as originating in their religious faith (Supiano et al., 2014; Cloyes et al., 2013). Inmate-volunteers may be inspired by a previous caring role, or by role models who were carers (Loeb et al., 2013). These studies also find that being an inmate-volunteer in the prison hospice is seen as a way of expressing one's true nature and demonstrating one's humanity to others, including prison staff (Loeb et al., 2013) and showing a shared humanity (Cloyes et al, 2013). As a result, inmate-volunteers “report that prison hospice creates a safe space within the overall hyper-masculine context of men’s prisons in which volunteers can let down their guard” (Cloyes et al., 2013, p.742).

Volunteering to work with dying prisoners has other impacts on the participants in these US studies. In choosing to accept a deeper relationship with the dying patient than would be usual outside of the prison, the inmate-volunteers working in the prison hospice make themselves more vulnerable to grief. Supiano et al. (2014) identify several ways in which these volunteers deal with their grief, including drawing resilience from their faith, from the support of their peers and prison staff and from their own sense of purpose. Memorialising the deceased prisoner is also important (Depner, Grant, Byrwa, Breier, Lodi-Smith, Kerr and Luczkiewicz, 2017; Loeb et al., 2013). Grief is regarded by these volunteers as acceptable and necessary, and crying comes easily (Supiano et al., 2014). Literature on the broader experiences of prisoners bereaved when another prisoner dies will be discussed below.

The experience of working with dying peers is also reported to have positive impacts. Bagnall, South, Hulme, Woodall, Vinall-Collier, Raine, Kinsella, Dixey, Harris and Wright (2015), writing about more general peer-support schemes in UK prisons, says the demands placed on peer-support workers (in this case, more

typically those providing education, support or access) gave individuals a sense of purpose and combated boredom. Cichowlas and Chen (2010) report the inmate-volunteers in prison hospices that they interviewed in the US took pride in the contribution they made, and described their work as a healing experience. Depner et al. (2017) elaborate on this, suggesting inmate-volunteers working in prison hospices experience 'post-traumatic growth', which leads to changes in their views about death, a greater acceptance of their own mortality, an ability to not take life for granted and increased compassion and tolerance for vulnerabilities, including their own. Inmate-volunteers in prison hospices are also found to have an increased sense of self-worth (Cloyes et al., 2013) and a sense of being special, with one interviewee describing themselves as being a “peculiar and unique person to do what hospice volunteer [sic] do” (p.741).

The US prison hospice programmes are also found to have a positive impact on the overall culture of the prison. Wright and Bronstein (2007, p.1) suggest that:

> *prison hospice programs [sic] have a transformative influence on the prisoners who volunteer for the program as well as on the overall institutional climate. Hospice appears to enhance the capacity to build and communicate respect, dignity and compassion among prison staff and prisoners.*

The prison hospice was seen as promoting the idea of caring, challenging staff and prisoners preconceptions of each other and changing the 'feel' of the establishment.

These studies suggest the role of a prisoner in caring for a dying peer is an important one in terms of personal and institutional transformation. However, it should be remembered that whilst prison hospices are not unique to the US, there are a large number of them in the US (69 as of 2011, according to Cloyes et al., (2013)) and no comparable schemes in the UK. The experience of prisoners employed as carers in the UK is likely to be different not least because their responsibilities, as described by Moll (2013) are very different.

2.5 Death and dying from natural causes in prison

Finally, consideration turns to the literature relating to deaths and dying from natural causes in prisons. Given the increase in the number of prisoners dying of natural causes, the paucity of studies in this area is striking. In recent years, with an increasing use of whole life tariffs, primarily in the US, and a changing prisoner demographic in many countries, academic research has begun to pay attention to

dying prisoners. However, the few studies that do exist typically focus on the experience of the dying prisoner (such as their fears about death or attitudes towards dying in prison (Aday and Wahidin, 2016)) or the provision of healthcare for the terminally ill prisoner (Turner, Payne and Barbarachild, 2011) from the perspective of Health Sciences. The impact of such deaths on prison regimes, culture and relationships remains overlooked.

This section will review what is known from the literature about prisoners' attitudes towards dying of natural causes in prison, and the impact these deaths have on the surviving prisoners. It will then consider the existing research on palliative care in prisons, going beyond the literature on the provision of healthcare for terminally ill prisoners to include the roles of other staff in the provision of palliative care in its broadest sense.

Prisoners and death

There are few studies addressing the concerns of prisoners facing the prospect of their own death in prison. The fear of death in prison is influenced by a number of factors, including witnessing how prison staff have treated the dead body (Aday, 2006) and seeing their peers in pain and humiliated as a result of the denial of or delays in medical treatment (Aday and Wahidin, 2016). Aday (2006) finds the fear of death amongst prisoners correlates to health variables, with those with more chronic and complicated medical conditions fearing death in prison most. Handtke and Wangmo (2014) suggest that when a prisoner knows their release date, their anxiety about death is reduced.

Death in prison may also be seen by prisoners as the 'ultimate failure' (Bolger, 2004, p.139) or 'the ultimate defeat, the ultimate punishment' (Aday, 2006, p.208). Prison is seen by most prisoners as the least optimal place to die (Aday and Wahidin, 2016), with prisoners on the whole preferring to die as free men, surrounded by their family (Crawley and Sparks, 2005). Aday and Wahidin (2016) express the problem for prisoners as being a lack of control over their own health and body because of the restrictions of the prison setting. Bolger (2005) argues a life-threatening illness compounds the losses already experienced as a result of imprisonment. She asserts that the individual's ability to cope with their illness is compromised by the circumstances of imprisonment. Wood (2007) posits that terminally ill prisoners are likely to feel without friends and family, hopeless, with nothing to look forward to and potentially remorseful for past actions. All of these aspects of their mental state, Wood (2007) argues, are likely to be problematic for the terminally ill prisoner. It is

recognised however that for some prisoners, death is seen as an escape, ending lives that have little social value (Aday, 2006), or even as an acceptable part of the punishment (Aday and Wahidin, 2016). Some prisoners however, in order to protect themselves, remain in denial about the prospect of dying in prison (Handtke and Wangmo, 2014).

Bereavement and grief among prisoners

The lack of research about the impact of these deaths on other prisoners is in keeping with the relatively scant attention paid to prisoners' experiences of other bereavements, including those of friends and family members who die whilst the prisoner is incarcerated. A number of authors (Aday and Wahidin, 2016; Masterton, 2014; Hendry, 2008; Olson and McEwan, 2004) have noted this omission, with Olson and McEwan stating "very little information can be found in the literature on bereaved prisoners, and it appears their grief may not be of great concern to others" (p.226).

When prisoners' experience of bereavement is the subject of research, the focus is on the effects of losing a family member whilst imprisoned (Masterton, 2014; Hendry, 2008; Olson and McEwan, 2004; Schetky, 1998) rather than on the death of a fellow prisoner. There are arguably some similarities between experiencing the death of a family member and the death of a fellow prisoner, with prison policies restricting prisoners' access to the normal rituals of grieving, the space and privacy to grieve, mementos of the deceased and social support regardless of the identity of the deceased. Bereaved prisoners will be expected to return to normal prison routines immediately after a death, with no opportunity to mourn (Aday and Wahidin, 2016). Schetky (1998) argues it is not just the prison regime that affects the grieving process, but also the prison culture: "the unwritten code of behaviour in prison is antithetical to the mourning process" (Schetky, 1998, p.384). Aday and Wahidin (2016) and Taylor (2002) support this, claiming a key characteristic of prison culture is that it does not welcome expressions of emotion. Similarly, Masterton (2014) who draws on her experience of providing bereavement counselling in a Scottish prison, concludes prison culture is not conducive to expressions of distress. Hendry (2008), writing about grief in prisons in New Zealand, links this to a more general masculine culture, not limited to the inside of prisons.

Whilst these studies illuminate the difficulties in general facing bereaved prisoners, they do not address directly the impacts on prisoners who have experienced the

death of a fellow prisoner. One of the striking aspects of this omission is that the literature does recognise long-term prisoners may be living with their only friends in the world (Aday and Wahidin, 2016) and that prisoners with life sentences in particular do worry about the health of other lifers (Schetky, 1998). Due to their imprisonment, the social world of long-term prisoners may be limited to other prisoners. Aday and Wahidin (2016, p.318) summarise this situation, writing:

> *"Losing close friends in prison may also be a harrowing experience for prisoners who frequently establish close kin relations with prison peers. In many cases, such losses are considered more significant than family on the outside".*

In practice, however, as Olson and McEwan (2004) find, "prison inmates and their relationships are often not well regarded by others. They may be considered disenfranchised grievers" (p.226). Doka (2002) describes disenfranchised grief as that which occurs when a loss is devalued, perhaps because the life lost is seen as less valuable. This could apply to any prisoner, whose crimes and imprisonment frequently lead to stigmatisation and rejection by wider society. Disenfranchised grief can also occur when those around the grieving person do not acknowledge their relationship with the deceased person, do not recognise the meaning to them of their loss or do not believe the person to be capable of feeling genuine grief (Doka 2002). Masterton (2014) suggests anger can be intensified by disenfranchisement. In a wider context, the idea that flawed grieving processes have long-term impacts on prisoners is supported by Schetky (1998) who finds unresolved grief is common amongst prisoners, but may be hidden by disruptive behaviours and Hendry (1998) who describes unresolved grief as affecting prisoners' ability to cope with prison life. The impact of the death of a fellow prisoner can also be seen in prisoners facing the prospect of their own death in prison (Aday, 2006; Aday and Wahidin, 2016).

Palliative care in prison

There are relatively few academic studies focussing on palliative care in prisons. As Burles et al. (2016) state: "Existing literature on prison palliative care is relatively scant, and whilst some programmes and guidelines exist, most of what is known has emerged from the American context" (p.100). This is supported by Turner, Payne and Barbarachild (2011) who identify only eight research papers on palliative care in prisons and three literature reviews during a 20 year period. Whilst studies agree there will be an increasing need (Burles et al., 2016; Turner, Payne and

Barbarachild, 2011; Bolger, 2005), this absence of academic studies of palliative care provision for prisoners is striking.

Wood (2007) suggests there are two main categories of difficulties in providing palliative care in prison; prison-related difficulties arising from the prison environment and the feasibility of effective care, and prisoner-related issues, which include the difficulties of facing death in prison. Turner, Payne and Barbarachild (2011) suggest that contrasting philosophies and environments exist between prisons and hospices. This is supported by a number of studies which highlight the tension between the values and aims of palliative care and prisons and find prison regimes at odds with the concept of a good death (Wrigley, 2018; Lillie, 2018; Burles et al., 2016). Bolger (2005) suggests prison allows very little personal choice, few opportunities to discuss the dying process or chance to involve the family, all important features of palliative care in the community. Turner, Payne and Barbarachild (2011) remind the reader that whilst the National Health Service (NHS) promotes choices for terminally ill patients, for example about where they die, these options are not available to prisoners. However, Wood (2007) argues "a 'good death' does not have to include control over location and timing" (p.133). For Burles et al., (2016) the prisoner's difficulty in accessing a good death can be attributed to a mix of political, social and personal factors, including public animosity and popular resistance to improving prisoner healthcare provision. Whilst Turner, Payne and Barbarachild (2011) suggest prisons and hospices share a position on the margins of society, Burles et al. (2016) argue dying prisoners are doubly marginalised. A prisoner's offences may prevent them accessing a hospice placement (Burles et al., 2016; Wood, 2007), with hospices being concerned that their charitable support will be compromised of they are seen by the public to be caring for prisoners (Wood, 2007).

The development of palliative care in prisons is regarded as slow (Bolger, 2005). Turner and Peacock report a number of positive developments, but also highlight reports by the Police and Prisons Ombudsman that are highly critical of the treatment of terminally ill prisoners, including the use of restraints. Research by Turner, Barbarachild, Kidd and Payne (2009) suggests prison governors are broadly supportive of prison healthcare teams' attempts to provide high quality end of life care in prison and that healthcare staff are starting to make links with local providers of specialist palliative care outside of the prison. Banks Howe and Scott (2012) report on initiatives to improve prison nurses understanding of palliative care.

Turner, Payne and Barbarachild, (2011) identify prison officers as also needing training in working with terminally ill prisoners, often lacking the skills, confidence or knowledge necessary. Any developments in palliative care are in the context of significant management changes which have transferred prison healthcare responsibilities to the NHS, stalling development (according to MacDonald and Fallon, 2008) but introducing new ways of working and giving nursing staff more influence on how healthcare in prison is delivered (Powell et al., 2010). Bolger (2005) argues transferring prison healthcare responsibilities to the NHS provides opportunities to develop palliative care services in prison, but finds the treatment of individuals with life-limiting or life-threatening illnesses in prison is not very advanced.

More general studies of prison healthcare provision highlight two particular difficulties in providing equivalent healthcare treatment in prisons that could be expected to have a particular impact on dying prisoners. The issue of access to drugs, including for pain release, is highlighted by a number of studies (Burles et al., 2016; Turner, Payne and Barbarachild, 2011; Condon, Hek, Harris, Powell, Kemple and Priscoe, 2007). They find a reluctance to administer drugs to relieve pain because of their potential misuse in the prison and a concern that vulnerable prisoners will be bullied if they have medication in their possession. Lillie (2018) reports that for terminally ill prisoners, difficulties in accessing analgesia in a timely fashion can lead symptoms to deteriorate. In addition, Powell et al. (2010) report on difficulties with referrals for treatment outside of the prison, with a lack of escort staff leading to cancelled appointments and in some cases complaints of medical neglect from the prisoner.

Whilst Turner and Peacock (2017) recognise prison officers may work closely with terminally ill prisoners, and emphasise that this work has emotional consequences which they do not necessarily expect and for which they receive no training, other non-medical staff also work with prisoners who are terminally ill. Key amongst these in England and Wales are prison chaplains and family liaison officers. Very little academic writing considers the work of the prison chaplain in the UK in connection with death and dying (Lillie, 2008) although there are studies of prison chaplains in the US. Similarly, the role of the family liaison officer (FLO), which is specific to prison establishments in England and Wales, is almost entirely overlooked in the current literature.

Craig (2002) is alone in focussing on the role of prison chaplains in prison hospices, although from a US perspective. He outlines their role in a multidisciplinary team as helping a terminally ill prisoner prepare for death. One of the three prison chaplains interviewed as part of Craig's study outlines their purpose saying "the emphasis is on bringing about a successful conclusion to a life that may seem a failure" (Craig, 2002, p.160). Their tasks also include facilitating family visits, often with the multidisciplinary team's social worker, addressing family members concerns about their relative dying in prison. In the UK, this is a role more typically performed by the family liaison officer (Bending and Malone, 2007).

Bending and Malone (2007), in outlining how the family liaison officer (FLO) role was established within prisons in England and Wales say "the role of the prison FLO is to manage the day-to-day relationship, treating the family appropriately, professionally and individually, taking into account cultural or lifestyle considerations, religious beliefs or any communication requirements" (p.25). The authors list a number of tasks the FLO is expected to perform, including breaking news of a death to the family, providing information to the family, offering support and practical help and signposting the family to bereavement and counselling agencies. Practical support provided by the FLO may include, according to Bending and Malone (2007), facilitating a visit by the family to the prison, introducing them to staff and prisoners who knew their relative, arranging the funeral and handing over the deceased prisoner's property. Whilst the FLO is not responsible for the care of prisoners or staff affected by the death of the prisoner, the authors acknowledge that their expertise can be of use. Interestingly, whilst the focus of Bending and Malone's (2007) work is on deaths by suicide, the family liaison officers they quote talk about the difficulties of sitting with distraught families at the bedside of prisoners dying of natural causes. Arguably, since Bending and Malone wrote their article in 2007, the work of family liaison officers will have changed to reflect the higher number of expected deaths in prison.

2.6 Conclusion

In reviewing the literature on deaths from natural causes in prison custody, it becomes apparent that whilst previous research does exist to inform approaches to the chosen research subject, the core issues have been overlooked. Consequently, there is very little research relating directly to the research questions of this thesis. Studies of deaths in the criminal justice system focus primarily on suicides, and to much lesser extent on homicides, displaying a concern for the causes of death

rather than the experience of death and dying and neglecting deaths from natural causes. Prisoner attitudes to the prospect of dying in prison are examined in only a very few studies and what studies exist looking at the experience of bereavement in prison largely neglect the loss of other prisoners, focussing instead on family bereavements. There is scant literature on palliative care in prison, with much of it based on US studies or highlighting only the limitations of palliative care in the prison setting. Research on prison regimes, cultures and relationships similarly overlooks deaths from natural causes in the prison setting. The role of prison officers, their part in the prison regime and their relationships with prisoners is well studied. However, the influence of other staff such as healthcare workers, who relate directly to seriously and terminally ill prisoners, is comparatively under-represented in research and the role of chaplains and family liaison officers, both significant figures at the end of life, almost entirely neglected.

The concept of a prison regime recurs within the literature. Although it is rarely defined, academics agree that prison regimes, and culture, vary between and within prisons. Governors and prison officers are seen to play an important role in setting and maintaining the prison regime and the culture of a prison or wing. There is remarkable consistency in the findings of previous research on prison officer culture, and a widespread agreement amongst studies of prison healthcare professionals that their occupational culture differs significantly from that of prison officers. There is also agreement amongst existing studies that staff (typically prison officers) and prisoner relationships are key to a well-run prison, although little attention has been paid to the relationships between prisoners and other staff members. Care has also been found to be part of prison culture by previous studies, although typically in more general terms than the care of the dying. Some of these omissions will be addressed by this study.

Chapter 3: Methodology

3.1 Introduction

This thesis aims to address two research questions:

> How do deaths from natural causes in prisons impact on prison regimes, culture and relationships?
>
> What determines the responses of prison regimes and personnel to dying prisoners?

In order to do so, qualitative data was needed to provide a rich picture, illuminating the experiences of prisoners and prison staff in relation to death and dying in prison custody. A combination of ethnographic methods was used to achieve this. Data was collected in four fieldsites: two prisons in northern England and two hospitals where their prisoners were sometimes treated.

This chapter provides an overview of the research methodology used to collect data. It will demonstrate the relevance of the chosen research methodology, beginning by outlining the research strategy chosen to address these questions and the reasons why the approach taken was judged appropriate. The methods used to collect data: participant observation, ethnographic conversations, semi-structured interviews and documentary analysis, will be discussed. Consideration will also be given to issues concerning access and the role of the researcher. The researcher's status as an insider is significant here. The approach used to analyse the data collected will then be summarised and explained. Subsequently, the fieldwork sites will be briefly outlined and issues related to access and participant recruitment will be discussed. Lastly, the chapter will consider the ethical issues of a research project of this type, including risks to both participants and the researcher, and questions of ethics around informed consent, anonymity, confidentiality and potential harm.

3.2 Research strategy

The chosen research strategy was informed by the research questions and by the researcher's own epistemological preferences. The use of ethnographic methods also reflected these two considerations. As an insider, the researcher was familiar with the prison environment but this status brings both advantages and challenges, summarised below. Participant observation, interviews and documentary analysis fitted well with aims of the research and their strengths and weaknesses as methods will be discussed. This section will also briefly introduce the chosen method of

analysing the data collected. Sykes's (1958, p.136) advice on the complexity of prison research informed the approach taken:

> *The realities of imprisonment are, however, multi-faceted; there is not a single true interpretation but many, and the meaning of any situation is always a complex of several, often conflicting viewpoints. This fact can actually be an aid to research concerning the prison rather than a hindrance, for it is the simultaneous consideration of divergent viewpoints that one begins to see the significant aspects of the prison's social structure. One learns not to look for the one true version; instead, one becomes attuned to contradiction.*

3.3 Insider research and the role of the researcher

For any prison researcher, the significant difference between themselves and the prisoners they study is that they are able to go home at the end of the day. Drake, Earle and Sloan (2015) claim this means that the prison researcher can never truly be an insider, yet arguably the researcher shares with prison staff the ability to leave the prison at the end of their shift, and prison staff are themselves a legitimate subject of study. A more useful explanation of insider researcher status is provided by Hodkinson (2005) who, from a study of a contemporary youth subculture as a long-term member, suggests a researcher can be an insider in one sense whilst not in another. O'Reilly (2012) echoes this: "All ethnographers are to some extent outsiders and to some extent insiders" (p.98). Hodkinson goes on to define insider research as "a means to designate ethnographic situations characterised by significant levels of initial proximity between researcher and researched" (2005, p.132) but does acknowledge this definition risks being based on simplistic ideas about identity.

A number of benefits are attributed to insider researchers, including the ability to screen participants' claims for credibility, to deploy pre-existing knowledge and to establish rapport (Bennett, 2016). Hodkinson (2005) suggests insider researchers don't have to 'perform'; they already have the ability to share subcultural gossip and swop anecdotes in ways that build rapport, and may be seen by participants as able to spot exaggerations and inaccuracies in data, to the extent that participants become more reliable. However, Hodkinson emphasises insider researchers do not have privileged access to a singular insider truth, simply additional resources to utilise in the fieldwork.

For Hammersley and Atkinson (2007) insider status can bring challenges. They emphasise the need for researchers to keep a distance and avoid feeling ‘at home’ if the quality of the data collected is not, in their view, to be compromised. However, Bennett (2016) suggests rather than ‘going native’ as is often regarded to be the risk associated with ethnographic research methods, discussed below, insider researchers have the beneficial option of ‘going academic’, using the preparation for the fieldwork and background reading to view a familiar environment from a sociological perspective.

Key to this is which role the researcher choses to adopt. In this research, publicising an insider status as a prison chaplain was essential for gaining access, establishing credibility with gatekeepers and explaining to participants why the research was being undertaken. In addition, although researching in prisons where I had not worked as a chaplain, inevitably there were some staff and a few prisoners who knew me from previous establishments. As a prison chaplain, I was fortunate in occupying a role within the prison service that was relatively neutral with regard to any tensions between prisoners and staff (Hicks, 2012; Craig 2002). Although assumptions were doubtless made about my beliefs and values because I was known to be a prison chaplain elsewhere, the same could be said of any researcher (Hammersley and Atkinson, 2007). Hammersley and Atkinson suggest participants are often more concerned about what kind of person the researcher is than the research itself. They suggest appearances matter, including clothes, speech and demeanour, but acknowledge some aspects of ‘front’ such as age, race and gender cannot be managed. Bennett (2016) reflects on choosing to dress differently when conducting research in prisons as opposed to when working as a prison manager. Similarly, Nyampong (2015) describes dressing as ‘mum’ or as ‘social worker’ when conducting an ethnography of youth custody in Ghana, in institutions where she had previously worked as a human rights monitor. Both of these researchers faced a similar dilemma to the researcher in this study: establishing a new ‘role’ and way of being within a familiar setting.

Nyampong (2015) describes struggling with her identity in her new role, and wondering which ‘hat’ the institutions being studied thought she was wearing. Something similar was experienced in this research project. There were occasions when it was notable that my dual status as both researcher and someone known to be an insider as a prison chaplain was being foregrounded by research participants.

This included incidences of prisoners asking about religious faith.[2] Amongst prison staff, it was chaplains in particular who blurred the boundaries, asking about practices in the prison where I worked as a chaplain[3] or even introducing me to prisoners as a chaplaincy colleague from another prison.[4] There were also times, particular after the death of a prisoner, when a concern for the well-being of a participant led to a risk of being drawn into performing my role as chaplain.[5] Similarly, there were other times when my responses were conditioned by my previous experiences in similar settings with a very different responsibility. Knowing I had experience of working in prisons seemed to help build a rapport with staff, but also with prisoners who rather than identifying me with prison officers because I was a prison service employee, seemed to regard my work experience as useful in terms of understanding at least some of their world.

3.4 Ethnography

In order to collect data to address these research questions, ethnography was identified as the most suitable methodology capable of producing the rich data required for a study of this nature. Ethnography includes a number of methods, and in this instance, participant observation, ethnographic conversations, document analysis and semi-structured interviews were established as most suitable for the research setting and likely research participants. This selection of methods, as well as being most likely to produce the type of data needed as will be seen, offered a degree of triangulation (Tashakkori and Teddlie, 2003) and enhanced the rigour of the data. Whilst not strictly a mixed-methods approach, collecting data using a range of methods enabled comparisons to be made. For example, interactions and acts could be observed within the prison and then considered in light of other data collected from documentary analysis, or related to the information offered by participants in semi-structured interviews. The development of the methodology for this research project drew on the established tradition of prison ethnography within the UK including recent studies in HMP Whitemoor (Liebling, Price and Shefer, 2011); HMP Wellingborough (Crewe, 2009); and HMP Wymott and HMP Garth (Crawley, 2004), which had also used a range of ethnographic methods.

O'Reilly (2012) suggests that whilst the definition of ethnography is contestable, ethnography involves direct and sustained contact with the daily lives of the group or

[2] Fieldnotes, Wakefield, 21/12/2018, 21/3/2018; Interview 14, Wakefield
[3] Fieldnote, Wakefield, 9/2/2018
[4] Fieldnote, Leeds, 16/2/ 2018
[5] Fieldnotes, Wakefield, 9/2/2018

individuals being studied over a period of time. She says it uses participant observation, conversations and other methods to reflect the complexity of social worlds and to tell "rich, sensitive and credible stories" (O'Reilly, 2012, p.3). The principle strength of ethnography as a methodology for this research is therefore the rich data it can provide, which brings the researcher closer to understanding the social worlds of research participants. Lofland (2006) claims that "only through direct observation and or participation can one get close to apprehending those studied and the character of their social worlds and lives" (p.3). There are, however, some criticisms of ethnography. Fielding (2001) contends the findings of ethnographic research can rarely be generalised to all similar settings, although in doing so he assumes this is the researcher's goal. He also identifies a risk of 'going native', claiming that the researcher needs to remain detached in order to collect and interpret the data. Lofland (2006) contradicts this, saying instead it is important not to be objective, and that bias avoidance is not a relevant issue. Similarly, in the context of research within prison, Liebling (2001) argues it is impossible for the researcher to be neutral, and that "researchers have to be affectively present as well as physically present in a social situation" (p.475).

3.5 Participant observation

Participant observation offers a number of advantages. Most importantly, it avoids the decontextualizing of data that can occur with data collection methods such as questionnaires and interviews (Lawton, 2001). It is defined as:

> *The process in which an investigator establishes and sustains a many sided and situationally appropriate relationship with a human association in its natural setting for the purpose of developing a social scientific understanding of that association. (Lofland, 2006, p.17)*

Four field observer roles were identified by Junker and developed further by Gold (1958): 'complete participant', 'participant-as-observer', 'observer-as-participant' and 'complete observer'. Although this typology has long been accepted, as O'Reilly (2012) explains there is contradiction between participation, which means the researcher is involved and subjective, and observation, where what is expected is a deliberate distancing and objectivity. Instead, she suggests participant observers should participate to the extent that research participants become used to their presence and the researcher can learn from their own experience of participating and empathise with the people being studied.

In this research project, a total of 295 hours were spent in the fieldwork sites over 12 months. The degree to which the researcher was a participant or an observer changed with the particular setting and varied over time. Participation was more difficult to achieve in the high security setting of HMP Wakefield, where the ability to move freely on a prison wing was limited because prison officers wanted to be able to see where any visitors were for their own safety, but it was still possible within O'Reilly's (2012) definitions. This is illustrated by a comment from one participant, when asked whether it was alright to stay on the prison wing after a death had occurred:

> *'To be honest, we don't notice you're here. You're part of the furniture, without wanting to be rude.'*[6]

My prolonged presence on the wing meant I was regarded by participants as part of their world; my presence was no longer noteworthy. This had obvious advantages in terms of being a participant observer in the prison. However, coupled with my status as an insider researcher, there was a risk of explanations not being provided, or sought, on aspects of the setting assumed to be understood. It was important to continually ask participants to provide the details and information they would offer to someone with whom they were less familiar.

The data collected through participant observation was recorded initially as brief notes in a notebook which was carried continuously, and then written up daily. O'Reilly (2012) warns a notebook can be a constant reminder to participants that they are being observed for research purposes. However, Crewe (2009) says in his prison ethnography a notebook was a useful tool to help participants identify him as a researcher. The notebook used in this fieldwork was chosen to fit neatly into a pouch on a key belt, and as such was largely unnoticeable, although at times a folder with participant information sheets and consent forms was also carried, and served as an identifier. The experiences of researchers conducting prison ethnographies informed a number of other practical matters, including the decision to limit fieldwork to a maximum of four days per week.

3.6 Interviews

O'Reilly (2012) says ethnographers may use a wide range of approaches to interviews, from opportunistic chats to in-depth one-to-one interview and suggests

[6] Fieldnote, Wakefield, 7/2/2018

researchers should take opportunities to ask questions informally or, if interviewing, will find unstructured interviews are best suited to ethnographic methods. However, she acknowledges this risks people not being aware they are being interviewed, and that higher status individuals may expect more formalised arrangements.

In this instance, the need to provide an interview schedule to meet the demands of ethics committees was one factor in the decision to use semi-structured interviewing techniques, rather than unstructured interviews, alongside ethnographic conversations. Semi-structured interviews enable interviewees to interpret questions and respond as they feel appropriate (Arksey and Knight, 1999; Rubin, 1995). The prison regime itself also meant unstructured interviews were likely to be challenging. Interviews needed to last between 45 minutes and one hour, to minimise the interviewee's absence from other tasks, and this was not achievable without some structure in place. In practice, staff members being interviewed often specified how much time they had available, depending on their role. Fifteen interviews with staff were held, with an average duration of 56 minutes. Whilst provision had been made in each prison for interviews with staff to be held in buildings outside of the main prison, in practice permission was given to take a Dictaphone into the establishments, which reduced the time staff were unavailable for other tasks. Interviews with staff were held in offices and meeting rooms. Permission had been given to interview up to three prisoners employed as carers in HMP Wakefield. In practice, there were significantly fewer than expected prisoners with experience of this role, one of whom participated extensively in ethnographic conversations throughout the data collection such that it was felt no further information would be solicited during an interview. One semi-structured interview was recorded with another prisoner-carer. This lasted 90 minutes and was held in an interview room on his wing.

3.7 Documentary analysis

As Hammersley and Atkinson (2007) point out, many settings are 'self-documenting', especially government departments, with members engaged in producing and circulating written material. These case reports, financial records, rulebooks and organisational charts, they argue, are crucially involved in social activities and as such should not be overlooked in ethnographic research. Her Majesty's Prison and Probation Service (HMPPS) produces a range of documents prescribing the functioning of prisons as well as reporting on incidents, activities and conditions. However, "the careful ethnographer will be aware that all classes of data

have their problems and all are produced socially; none can be treated as ‘transparent’ representations of ‘reality’” (Hammersley and Atkinson, 2007).

There is no single document from HMPPS detailing the ‘rules’ relating to dying and deaths from natural causes in prison custody. Instead, the needs of prisoners dying of natural causes, the provisions for their care or suitable responses after a prisoner’s death from natural causes are referred to across several relevant sources. These were reviewed as part of this research project and included several Prison Service Instructions (PSIs) and Prison Service Orders (PSOs) as well as reports by the Prison and Probation Ombudsman (PPO), Her Majesty’s Chief Inspector of Prisons and the Independent Monitoring Board for each fieldwork prison. In addition, Prison Rules (1999) and the ruling in R(Graham) vs Secretary of State for Justice (2007) were reviewed. These documents were selected because they direct the responses of prison staff towards terminally ill prisoners and specify the actions to be taken in relevant circumstances, including during treatment in outside hospitals and immediately following a death from natural causes. Collectively the documents demonstrate the underlying approaches taken by Her Majesty’s Prison and Probation Service towards prisoners dying of natural causes. They set what Foucault (1991b, p.80) calls the “rational schema” of prisons:

> *We are dealing with sets of calculated, reasoned prescriptions in terms of which institutions are meant to be reorganised, spaces arranged, behaviour regulated.*

These documents were studied prior to the fieldwork commencing as part of familiarisation with the prison rules informing the care of terminally and seriously ill prisoners. Whilst these documents provided data in themselves, discussed in chapters four, five and six, they also helped identify ways in which prison staff might be seen during the fieldwork to deviate from the ‘rules’.

The documents reviewed

A range of documents relate to the needs of prisoners dying of natural causes or the provisions for their care but there are also omissions. The statutory instrument, the Prison Rules (1999), is comparatively brief and forms the basis of the regulations governing the functioning of prisons. With regard to prisoners, the Prison Rules briefly covers their treatment in general. There are also sections on officers, on the Board of Visitors (now known as the Independent Monitoring Board) and other visitors to the prison, but also a number of significant omissions (Loucks, 2000). The

brevity of the Prison Rules leaves scope for discretion for prison authorities and requires considerable additional rules, regulations and guidance to be issued (Loucks, 2000). Although they are a statutory instrument, the Prison Rules, as with the PSOs and PSIs discussed below, are not legally enforceable; prisoners cannot use them as a basis on which to sue for a breach of statutory duty (Loucks, 2000).

Parts of two Prison Service Orders (PSOs) were reviewed. PSOs are the mandatory instructions intended to be permanent, until replaced by a Prison Service Instruction (PSI) or cancelled, and take precedence over other mandatory manuals (Loucks, 2000). As such, they have no expiry date, although none have been issued since 2009. From PSO 0200, which is the Standard Manual, Section 20 relates to handling a death in custody, and was updated in November 2005. PSO 3050, the 'Continuity of Healthcare for Prisoners', which was issued in February 2006, was also included in this review.

Prison Service Instructions are the rules, regulations and guidelines according to which prisons operate. They can be regarded as short-term directives (Loucks, 2000). Some of their provisions are mandatory; others are not. One of the key recommendations of the Woodcock inquiry (1994) into escapes from the Special Security Unit at HMP Whitemoor was that prison service manuals and instructions should make it clear which provisions are mandatory, advisory or purely informative. In the PSIs and PSOs this is done by italicising text referring to mandatory actions. Five PSIs were reviewed, as follows:

- PSI 64/2011 Management of prisoners at risk of harm to self, to others and from others (Safer Custody), updated April 2012 and still in use, notwithstanding an expiry date of 31 January 2016. Despite its title, this PSI is relevant since it also includes the management of prisoners who are terminally or seriously ill, and actions to be taken, such as liaison with families, following a death in custody from any cause,.
- PSI 17/2015 Prisoners Assisting Other Prisoners, effective from April 2015, which formalises the support and care prisoners in need of physical assistance can receive from their peers.
- PSI 33/2015 External Escorts, effective from December 2015, which is part 7.1 of the National Security Framework and details arrangements for when a prisoner is taken outside of the prison, including to attend hospital.
- PSI 03/2016 Adult Social Care, updated April 2016 and largely concerned with the implementation of the Care Act 2014 and the provision of local

authority social care to prisoners. Whilst not all terminally ill prisoners will require social care, this PSI also refers to palliative care for prisoners and compassionate release.

- PSI 05/2016 Faith and Pastoral Care for Prisoners, updated June 2016 and included in the review because it details expectations regarding the role of chaplains in providing pastoral care for terminally or seriously ill prisoners, liaising with their families and supporting staff affected by a prisoners' death.

The review of relevant documents also included the ruling by Judge Mitting in the High Court in 2007 in R(on the application of Graham and another) v Secretary of State for Justice, which provides case law precedent for the use of restraints on prisoners receiving medical treatment. The judgment includes consideration of the application of article three of the European Convention on Human Rights and is reflected in PSIs concerned with external escorts of prisoners and the use of restraints.

3.8 Data collection

Data collection took place at a number of relevant sites, primarily two prisons, HMP Wakefield and HMP Leeds, and in the hospitals to which their prisoners were transferred when healthcare services within the prison could not meet their medical needs. One of the most obvious advantages for the insider researcher is that access to fieldwork sites may be easier, but as will be seen there are other considerations in securing access, particularly when researching vulnerable participants in public institutions. How these participants were recruited once access to the institutions had been secured will also be considered here.

Research sites

The Prisons: HMP Wakefield and HMP Leeds

Lofland (2006) suggests potential sites for fieldwork should be evaluated to assess their appropriateness, ease of access, the physical and emotional risk associated with the site and any relevant ethical considerations or personal consequences, in addition to their 'fit' with the research aims. Fieldwork sites could be chosen as representative or as atypical and whilst the choice of site may be theoretically informed, it may also be limited by practical factors (O'Reilly, 2012). With this in mind, the sample size of two prisons reflects the geographical location of the researcher and the relatively limited available time for an ethnographic study (12 months) which made a larger sample impractical. The use of two fieldwork sites was

intended to benefit the research project by providing an opportunity for comparisons and contrasts (Fielding, 2001).The two fieldwork prisons were chosen as the most appropriate available to address the research questions, based on their purposes and the characteristics of the prisoners they housed. Both prisons accommodated only male prisoners. Men constitute typically 95% of the prison population of England and Wales and 97% of the deaths from natural causes in prison (Ministry of Justice, 2018).

As part of the Long Term and High Security Prisons Group, HMP Wakefield houses long-term prisoners, the vast majority of whom are serving more than 10 years (HMCIP, 2018), including a large number of sex offenders. It has an average population of 740 men, typically in single occupancy cells, including category A and High Risk category A prisoners. The prison is situated in the city centre of Wakefield, between the railway station and a brewery, on a site it has occupied since 1594. The current building is a large, mostly Victorian structure, with an elegant clock tower, and four wings (A–D), each four storeys high, radiating from a central hub. Separate buildings house a healthcare centre, a segregation centre, which includes a Close Supervision Centre, and administrative functions. There are also several workshops where prisoners are employed in tasks such as braille translation, carpentry, recycling and manufacturing clothes. Others work in the prison kitchen or have tasks on the wing. Education classrooms and rehabilitation programmes are provided in centres attached to the main prison. The most recent visit by Her Majesty's Chief Inspector of Prisons, an unannounced inspection conducted during the fieldwork period, found "the prison was calm and had an atmosphere that spoke of good order, safety, security and decency" and described it as "an essentially respectful prison, with many examples of good relationships and interactions between staff and prisoners" (HMCIP, 2018a, p.5). HMP Wakefield was of particular interest for this research because it had prisoners employed as carers for their peers who were physically frail, terminally or seriously ill. Given the population of HMP Wakefield included some prisoners assessed as posing the highest security risk (category A), it was anticipated that HMP Wakefield would face challenges in caring for terminally ill prisoners linked to the security requirements of the establishment.

By contrast, the second prison, HMP Leeds, was chosen because it was a local prison, with a higher 'turnover' of male prisoners, including many on remand, housing up to 1,212 category B prisoners. Like HMP Wakefield, it is a Victorian

prison, built in 1847, situated not far from Leeds city centre, in the historically working class district of Armley. It occupies a prominent site and has a foreboding, castellated gatehouse, currently used as offices. The original building, like HMP Wakefield, had four wings, A–D, but additional residential units have been added to create a total of 667 cells, most of which contain bunk beds and are shared occupancy. Further buildings have been added resulting in a layout which is difficult to navigate. HMP Leeds includes a 'first night unit' to accommodate and facilitate the induction of the large numbers of new prisoners arriving each day. It also has a Segregation Centre and a social care wing which includes provision to accommodate 17 prisoners in need of social care. During the period of fieldwork, Her Majesty's Chief Inspector of Prisons published a report on an unannounced inspection of HMP Leeds carried out in October and November 2017. This found HMP Leeds to be an unsafe prison where "levels of violence of all kinds were far too high" and to be "one of the most seriously overcrowded in the country" (HMCIP, 2018b, p.5).

These prisons were also selected because they had experienced a relatively high number of deaths from natural causes amongst prisoners in the five years prior to the research: 13 at HMP Leeds and 33 at HMP Wakefield, the second highest in the country. It was also of interest that they occupied Victorian buildings, a common design of prison, identified as presenting particular challenges to the care of elderly (and by extension frail or dying) prisoners (Crawley, 2005b). HMP Leeds was also of interest because of its intermediate social care unit and HMP Wakefield because of its in-patient healthcare facilities. This provision enabled the observation of the care of terminally and seriously ill prisoners within the establishment as well as at 'outside' hospitals.

The different purposes of the two prisons, and especially the very different rates of turnover in prisoner population, led to different approaches being taken to data collection. The more static population at HMP Wakefield, where the atmosphere reflected Her Majesty's Chief Inspector of Prisons' finding of calmness and good order, lent itself better to ethnographic methods and to on-going fieldwork than the rapidly changing population of HMP Leeds, where although some participant observation was conducted, there was a proportionately greater emphasis on semi-structured interviews. Fieldwork at HMP Leeds was conducted in three short periods, each of two–three weeks, when the researcher visited intensively. In HMP Wakefield, research relationships were established and maintained over the full 12

months of fieldwork. A decision was taken not to attempt to disguise the identity of the two prisons used as fieldwork sites, in keeping with the view of Crewe (2009) that guarantees of institutional anonymity are useless in the context of research in single (or in this case very small) case study samples. Providing any contextual information, such as prisoner population, prisoner demographic or the size or age of the prison building, necessary for this research, would inevitably enable identification of the prisons used for the fieldwork.

Of great importance in the selection of fieldwork sites was that the prisons would not be previously known to the researcher and could therefore mitigate some of the pitfalls of insider research. The decision to conduct research in unfamiliar establishments is in accordance with advice from Bennett (2016), who conducted ethnographic research in prison whilst working as a prison manager, and argues choosing an unfamiliar prison helps create a distance beneficial to the research and addresses some of the challenges of insider research.

The Hospitals: Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Trust

The selection of hospitals within which research was conducted was based on information from the Governing Governors and Safer Custody Managers in each prison about where prisoners requiring medical treatment beyond that available in the prisons would be taken. Two hospital trusts were identified: Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Trust. It was expected that when necessary prisoners would be transferred for treatment to either Leeds General Infirmary, St James' University Hospital, Pinderfields General Hospital, Dewsbury and District Hospital or Pontefract Hospital. At the outset of the research it could not be estimated which hospitals would receive a seriously or terminally ill prisoner who was willing to participate in the fieldwork. In practice, four incidences of prisoners receiving in-patient treatment in public hospitals were observed. Three of these were at St James' University Hospital, where the prisoner was sent from HMP Leeds, and one at Leeds General Infirmary, involving a prisoner from HMP Wakefield. All the prisoners observed being treated at St James' University Hospital were located in individual side rooms. The prisoner receiving treatment at Leeds General Infirmary was on a small ward, with two other patients, with the curtain permanently drawn closed around his bed.

Access

Although there was still a complex process of gaining ethical approval for the research, discussed below, insider-researcher status within HMPPS undoubtedly helped gain access to the research sites. It was relatively straightforward to approach a colleague in the senior management team at the prison where I was employed as a chaplain to discuss fieldwork sites and ask for an introduction to the Governing Governors at the two preferred sites. This was done by the senior management team member by email, with the Governing Governors responding positively almost immediately. Although it was surprising to get replies within half an hour, Bennett (2016) allows that access to prisons for research is considerably easier for insiders because of these personal contacts. O'Reilly reminds us: "access is not separate from research itself; from it you learn about how people view things, what they want to see and what they do not, and how they understand your role" (O'Reilly, 2012, p.90). The encouraging response from Governing Governors to this initial email, and at subsequent meetings to discuss the research in more depth, perhaps indicated a strong desire to see research on this subject, or maybe a willingness to support the studies of an insider. Both establishments had previous positive experiences of hosting research, and in each prison a lead contact person, based in the Safer Custody Team, was identified by the Governing Governor as a contact point. These individuals served as further 'gatekeepers', although to a lesser extent than the Governing Governors.

The location of the data collection, within prisons and hospitals, necessitated gaining permission from both HMPPS National Research Committee and the NHS England Health Research Authority. An element of this was about securing ethical approval for the research, but the application process also including getting permission to access the fieldwork sites. Both Governing Governors providing letters of support which were part of the HMPPS National Research Committee's deliberations and confirmed the Governing Governors were willing for their establishments to be used in this way. With the NHS however, it was necessary to get Health Research Authority ethical approval and to then subsequently apply for a 'Research Passport' and obtain a 'Letter of Access' from each NHS Trust where participant observation of prisoners attending hospital would occur. Permission was also obtained from the Health and Justice Commissioning Manager, responsible for commissioning healthcare services in secure and detained settings, including prisons.

Recruitment

Recruitment to the fieldwork was essentially purposive, with elements of snowball sampling, but also included the use of reflexivity in order to ensure it was not just convenience sampling (O'Reilly, 2012). In order to facilitate effective ethnography, it was envisaged that the initial phase of the fieldwork would include the researcher attending a wide range of meetings, events and fora within each of the prisons, with the intention of building awareness of the research and familiarity with the researcher, and providing staff and prisoners with the opportunity to ask questions. In practice, this was more achievable in HMP Wakefield than in HMP Leeds, where there were far fewer meetings involving groups of prisoners. In HMP Wakefield, these activities were important in recruiting participants, and crucially, gave people the opportunity to express a wish not to participate. In each prison, a Staff Information Notice (SIN) and a Prisoner Information Notice (PIN) was issued in the week prior to the fieldwork commencing (see appendices). SINs and PINs form the main method in which information is communicated within prisons, and at the suggestion of the Safer Custody Manager in one of the participating prisons, a photograph of the researcher was included to assist identification. A global email was also sent to all staff at the outset. Prisoners working on the Prisoner Information Desks in each prison were given a verbal briefing about the research as well as copies of the participant information sheet to distribute to any interested or concerned prisoners. This was repeated at HMP Leeds prior to each period of fieldwork but not felt by staff at HMP Wakefield to be necessary because of the researcher's ongoing presence and the very static prisoner population.

The participant information sheet (included in appendices) sought to reassure potential prisoner participants that being asked to be involved did not mean they were seriously ill or near the end of life. Instead they were being asked to be involved in this research because they spent time in places where prisoners who are seriously ill or approaching the end of life were together with the prison staff. They were reminded the researcher had no access to medical records or to any prison service record.

The intention was to approach potential participants in person, to explain the project and seek their consent. Whilst this happened as planned, there were also many occasions on which prisoners approached the researcher, having heard about the research, or simply curious about the presence of a visitor. It was necessary to be proactive in seeking to observe occasions when staff accompanied prisoners to

hospital for in-patient treatment. When these occurred was identified at various times in liaison with the Safer Custody team, healthcare staff, the duty governor or Detail staff. In keeping with a requirement from HMPPS that in-patient participants must consent in advance to being visited, a member of staff made the initial approach on my behalf. In practice, changes to a prisoner's treatment sometimes meant a hospital stay was shorter than expected and arrangements to undertake participant observation in hospital had to be cancelled.

Interview participants were identified in two separate ways. In HMP Wakefield, there was a limited number of prisoners working as prisoner-carers for frail and terminally or seriously ill prisoners. These were identified by their work records by staff in the Safer Custody Team. With regard to staff, recruitment for interviews was through snowball sampling with participants approached and selected because they occupied specific roles or fulfilled certain functions within the prison. They were contacted via a Global email, through staff information notices and in person, and asked to complete a selection questionnaire to ensure only staff with relevant experience were interviewed.

Interviewees were selected to reflect a range of roles within the prison and to ensure, as far as possible, a balance in terms of gender, age and years of service. Seven semi-structured interviews were held with staff in HMP Leeds with two healthcare professionals, four prison officers (including three with experience as family liaison officers, one of whom was a Senior Officer) and one chaplain. In HMP Wakefield, eight interviews were held. The interviewees included two governors, one Custodial Manager, two prison offices (one of whom was also a family liaison officer) one nurse, a chaplain and an education worker. Age was recorded by age band, with the oldest interviewee indicating they were 56–65 years old and the youngest 25–35 years. Eight of the staff interviewed were male and seven were female. The longest serving member of staff had been with the prison service for 30 years; the most recent recruit had been in post for two years.

3.9 Analysis

Analysis is “a kind of transformative process in which the raw data are turned into ‘findings’ or results” (Lofland, 2006, p.195). O’Reilly (2012) defines analysis as sorting and exploring data in preparation for presenting the data to a wider audience, making sense of it and telling the story of what has been heard and seen. In ethnography, she says, notes collected chronologically need to be re-ordered into

categories, which may be thematic or descriptive or both. This was particularly true in this research project, where data was collected over the course of a year. O'Reilly (2009) makes the case that analysis is a reflexive process in which data collection and analysis are not separate phases, but intrinsically linked, such that it "is far more likely that the ethnographer will progress as in a spiral" (p.15). Ethnography is thus an iterative-inductive process (O'Reilly, 2012). Hence in this research, analysis began during the fieldwork, with reflexive notes being made developing possible links between data, recording emerging insights and highlighting repeat occurrences of the same topics, terms, and practices. This on-going analysis was invaluable in helping identify gaps in the data and provided a focus for the continuing fieldwork.

The nature of prisons as closed institutions meant access for data collection had to be agreed for a fixed period. This resulted in a greater distinction between fieldwork and analysis than O'Reilly (2009) suggests, although she acknowledges that the researcher has to leave the field at some stage. Once the fieldwork phase ended, NVivo11 and 12 software was used to assist in the coding of data and the identification of themes. A thematic approach was taken, enabling patterns within the data to be identified, together with their relationship to each other and potential relevance to the research focus (Bryman, 2015). The aim was to both summarise what people do, but also why they act and talk as they do (O'Reilly, 2009) and to identify concepts which help make sense of the data (O'Reilly, 2012).

Using computer-assisted qualitative data analysis software (CAQDAS) such as this has a number of advantages, including allowing for easy retrieval of data and for several codes to be associated with the same data, more accurately reflecting the complexity of the social world, where "data does not present itself to the ethnographer one theme at a time" (Hammersley and Atkinson, 2007, p.155). CAQDAS also facilitated the re-coding of data as ideas about the data developed and changed with further analysis, removing codes by "winnowing out less descriptively and analytically useful ones" (Lofland, 2006, p.201). The risk of using CAQDAS to analyse data thematically is that the context can be lost. Newer software, such as NVivo11 and 12, allows data extracts judged to be important to be re-contextualised as needed.

3.10 Ethical considerations

Any researcher has responsibilities to participants, key informants, funders, gatekeepers and future researchers to conduct ethical research (O'Reilly, 2012).

The principal ethical considerations in this research project were those typically associated with conducting research in a prison and amongst prisoners, and in researching a sensitive subject. These include ensuring participation is informed and voluntary and protecting the well-being of all participants and the researcher. For prisoners, their incarcerated status means there are additional issues concerning giving informed consent, and vulnerabilities, particularly with regard to confidentiality and anonymity.

Ethical issues in researching end of life

On important ethical consideration was whether to seek to include terminally ill prisoners as participants, and if so, to what extent any risks could be minimised. The literature on the ethical appropriateness of qualitative research with the terminally ill is inconclusive. De Raeve (1994) suggests there is perhaps no justification for research involving the dying, given the potential for disrespect of the emotional and physical state of people who are approaching death. In contrast, Lawton (2001) argues it is paternalistic to suggest people receiving palliative care are too fragile to participate in qualitative research and that this population can find a therapeutic benefit in having a voice. Similarly, Barnett (2001) suggests whilst being interviewed could be a painful experience for terminally ill people, participants were glad to have done it. Barnett (2001) also argues that to exclude them from discussions of the issues that concern them would be paternalistic. Kendall, Harris, Boyd, Sheikh, Murray, Brown, Mallinson, Kearney, Worth and Workman (2007) suggest “some people’s desire to participate in research at the end of life may itself be an example of resistance to social death, an opportunity to be an active and participating citizen again rather than an invalid or patient” (p.527). In contrast, Hammersley and Atkinson (2007) say ethnographers need to avoid creating anxieties. They give the example of research involving those who are dying, which they say may be judged to be unethical. If qualitative research is to include terminally ill participants, Kendal et al. (2007) advise researchers to proceed as if people do not know they are dying, unless they explicitly acknowledge they are, and to avoid asking direct questions about death and dying.

Bearing this conflicting advice in mind, it was decided to focus on conducting participant observation in the locations within the prison where interactions between staff and terminally or seriously ill prisoners take place, rather than on identifying individuals with a terminal diagnosis. This included the prison healthcare centre and any accommodation units adapted for this prisoner group, as well as prison wings. It

was felt to be unnecessary and unethical to request access to prisoners' medical information or to seek to identify which prisoners were medically diagnosed with a terminal illness. Furthermore, the research questions included situations when a death from natural causes was unexpected, where no previous diagnosis may have been made. The research questions could be adequately addressed by looking at cases where prisoners were regarded by staff and other prisoners as seriously or terminally ill, without this being medically confirmed, even if diagnosis had been possible. Given the nature of the research questions, it was not felt necessary to interview terminally or seriously ill prisoners, although the chosen methods allowed for ethnographic conversations which could, with the prisoner's consent, be included in the research data, but which were likely to be less burdensome for a physically frail prisoner than a more formal semi-structured interview.

Risks to participants and researcher

Crewe (2009) says one of the first things he learned when conducting an ethnography in a prison was that the prison was a safe environment. As an insider, I had the advantage of being familiar with prisons and having worked within other prisons, in a different role, safely. I already had training from HMPPS in personal protection, security awareness and anti-corruption practices, and a good awareness of the rules and practices in place to ensure safety. This included not being alone with prisoners regarded by the prison authority as not safe for one-to-one meetings. My willingness to conform to the security practices I knew to be expected, such as staying in sight of prison officers when on a wing, may have placed limitations on the research, but was essential to maintaining credibility with 'gatekeepers'.

The principle risk to participants in the project came from the sensitivity of the research topic. Discussing death and dying may be upsetting. Whilst I had experience of talking about these topics with prisoners and prison staff, from my role as a prison chaplain, from facilitating death cafes in the prison where I work and from previous research with prison officers, it was important to have other sources of support available to participants. Briefings were provided for each prison's Listeners and staff care team. In HMP Wakefield, I attended meetings of the Listeners, prisoners trained by the Samaritans to support their peers, so they could ask questions. This was not possible at HMP Leeds, where meetings were not held for Listeners, so each Listener was met individually at the start of the first period of fieldwork, something repeated with the Listeners on the relevant wings at the beginning of subsequent visits. Listeners and members of the staff care team were

given details for the research in advance (but not told who was participating) in the hope they would be better able to support anyone who had been upset by the research. Because the subject of death and dying could be particularly upsetting, the Safer Custody Team in each prison was regularly asked to identify any prisoner they felt should not be approached about the research. In practice, they typically felt unable to do so. I was aware I might also find the topic upsetting at times, and so support, including from a trained counsellor with experience of working with staff in the criminal justice system, was in place before the fieldwork commenced.

Informed consent

Hammersley and Atkinson (2007) claim ethnographers rarely tell their participants everything about the research, partly because they may not know the detail of the study at the start, but also because participants may not be interested in the project and to give them unwelcome detail would be intrusive. The freedom to follow their advice in this project was curtailed by the requirements of the NHS Health Research Authority and HMPPS. A detailed participant information sheet was produced, and, in recognition that not all prisoners (or indeed prison staff) would have the ability or time to read it, potential participants were also talked through the research. These explanations were inevitably partial, but the potential participants were given copies of the PIS and consent form, and asked how long they needed to decide whether to participate.

Informed consent, especially in ethnography, is problematic. It needs to be recognised, as Miller and Bell (2002) suggest, that the formality of consent forms may alienate some people. This was felt to be particularly the case for prisoners, for whom a signature on a consent form may be more associated with signing something away, with a loss of power, than with giving their consent. However, it is expected by ethics committees. Miller and Bell (2002) also suggest there may be problems telling where 'participation' begins and ends, something particularly acute in ethnographic research where the researcher aims to fade into the background such that participants may forget they are there. Murphy and Dingwall (2007) say consent in ethnographic research is based on trust and is relational, rather than contractual. During the course of the fieldwork, two participants explicitly explained their willingness to participate as originating from having decided I looked trustworthy.[7] However, Murphy and Dingwall (2007) suggest that as such, consent

[7] Fieldnotes, Wakefield, 6/3/2018, 4/4/2018

can be withdrawn at any time. This fits closely with other writers (O'Reilly, 2012; Hammersley and Atkinson, 2007; Miller and Bell, 2002) who say informed consent in ethnography needs to be ongoing and renegotiated. It was important throughout this research to check with participants whether something could be included in the data collection.

The importance of informed consent being an ongoing process was especially relevant to this research given the topic being studied. It was possible some participating prisoners could lose capacity to give informed consent during the course of data collection, in which case it was intended that no further observations would be conducted unless and until the prisoner regained the ability to consent. Participants were informed of this on the information sheet, and asked in advance to give their consent to the data collected before they lost capacity being retained in the study. In practice, there was no ambiguity regarding a participant's ability to consent and any observations with a participant were completed before their capacity to consent became doubtful.

Prisoners participating in the research were also vulnerable because of the power structure of the prison. However, as Fielding (2001) says, groups that are powerless or vulnerable still have a right to be researched. Chan (2012), writing about researching police officers, suggests this is not just a problem for prisoners, but can affect staff in command and control settings such as police forces. This arguably also applies to prison staff. The participant information sheet was clear that participating or not would not affect a prisoner's chance of parole or their treatment in the prison, and that it would not count towards the prison's targets for 'purposeful activity'. This did not stop one prisoner feeling having a copy of the signed consent form helped him secure re-categorisation as a lower risk.[8] It was also emphasised that anyone could withdraw from the research at any time, without having to give a reason. To try to ensure consent was genuine, all potential participants, including staff, were given 24 hours to consider whether to participate. It was important even then to be sensitive to non-verbal expressions, and whether they matched spoken expressions of consent (Nyampong, 2015).

Given a prisoner population of 740 in HMP Wakefield and 1212 in HMP Leeds (where 40% of the population changed every three months and up to 70 new prisoners might be received each day) it was not practical to gain the written

[8] Fieldnote, Wakefield, 4/4/2018

consent of prisoners and staff who were tangential to the research being conducted. Limited data was gathered from these people, all of it anonymous and none of it personal or sensitive. Only when it seemed likely that someone would become more significant in the research was their consent sought, an approach regarded as the only practical solution by Murphy and Dingwall (2007) to research in 'semi-public' spaces where people know their behaviour can be scrutinised in person or via CCTV. This approach was taken because it was felt a prison was such a space.

Anonymity

Whilst ethics committees encourage researchers to ensure the anonymity of their participants, Wahidin and Moore (2011) argue it is more important potential participants are informed if there is a chance they could be identifiable from the research report. As discussed above, it was felt futile and unhelpful to attempt to maintain the anonymity of the institutional settings for this research and so the risks needed to be acknowledged. Participants were reminded of how the data would be used and informed it was possible people may try to guess who has taken part in the research project. Staff participants were more likely to be identifiable if there were not many people in a particular job, for example working as family liaison officers. For this reason, it was felt necessary to ask those at risk of identification in this way whether their role could be mentioned. Similarly, one prisoner participant was keen to check how he would be referred to in the data, anxious not to be identifiable given he was one of a small number of prisoners with a very specific sentence. An appropriate formulation was agreed with him.[9]

There were also difficulties in protecting participants' anonymity during data collection. In the high security prison in particular, ethnographic conversations with prisoners took place where the interaction could be overseen, and potentially overheard, by staff and other prisoners. Occasionally pre-arranged conversations with prisoners were held in interview rooms. Each time this happened, prison officers had to be told who was to be seen, then call or fetch the prisoner, and give him a rub-down search before the interview commenced. The fact the prisoner had participated in the research could not be disguised, even if the content of the conversation was confidential.

[9] Fieldnote, Wakefield, 31/1/2018

Something often overlooked in prison research is the difficulty of protecting the identity of staff participants from their colleagues. When staff members participated in semi-structured interviews, as with prisoners, it was hard to avoid their participation being noticed. Offices often had glass walls, or were accessed through public spaces, and most staff interviewees struggled to find a place to talk where we would not be interrupted. Furthermore, if prison officers who routinely worked in prisoner-facing functions were to be interviewed without disrupting the normal regime, other staff within the prison needed to be told who was participating in the research so they could be replaced. This was a foreseen difficulty. Discussions with the Safer Custody Team in one prison, and at the daily meeting of Residential Custody Managers (CMs) in the other, led to an arrangement whereby, if the officer to be interviewed consented, the team who prepared staff rotas were contacted by the researcher to arrange cover for their tasks. Other instances demonstrated the limited extent to which officers actually expected or desired anonymity, volunteering their participation in front of colleagues and prisoners.

It was recognised that some of the data collected could be sensitive, for example relating to criminal activities or providing personal information about prisoners or prison staff. With this in mind, as far as possible the data was anonymised when collected. When transcription was required, for example of interview recordings, this was done by the researcher. Interviews were anonymised as transcribed, with any names or personal details which might assist identification being removed. Names are only used in this thesis when it assists the reader in keeping track of cases referred to across several chapters, and are all pseudonymised. Distinctive speech patterns are not quoted verbatim, again to protect the identity of participants.

Confidentiality

In order to respect the confidentiality of prisoners, situations where confidential medical information might be overheard, for example in appointments with medical consultants, were not observed and a decision was taken not to have access to either medical or prison service records for any prisoner.

All data was handled in accordance with current legislation and guidelines from the University of York and the British Sociological Association. There were some exceptions to confidentiality required by HMPPS, specifically if participants shared information suggesting they intended to cause harm to themselves or to others, if there was a serious threat to prison security or illegal activities, malpractice or

breaches of prison rules. In these circumstances, this information had to be shared with the appropriate member of staff, although in practice this never arose. All potential participants accepted the warning that their confidentiality might have to be breached. This was a proviso, required by HMPPS, that seemed familiar to staff and prisoners alike, yet as Israel and Gelsthorpe (2017) point out, it is one in which the researcher demonstrates a privileging of institutional loyalty over the interests of research participants. What was significant was the response this proviso elicited in some staff. They were unaccustomed to being included in the same stipulation as prisoners and some of them seemed surprised at this part of the consent form. Despite feeling uncomfortable, the researcher continued to highlight this proviso, partly in order to fulfil the commitments to a research ethics committee but also because of a desire to treat staff and prisoners alike in this regard.

Data storage

Three forms of data were collected that were not anonymised at the time of collection. The careful storage of this data was important to maintain the confidentiality of participants, and assurances about its protection were important to participants. Completed consent forms (see appendices for format) were removed from the prison, electronically scanned and stored on the secure University of York's filestore, with the originals being destroyed as confidential waste. Selection questionnaires, completed by staff willing to be interviewed, were stored in a locked drawer in the prison, anonymised as transcribed within the prison, with any personal identifiers removed, and the transcription emailed to be stored on the University of York's filestore. Originals were then destroyed using the prison's confidential waste system. Interview recordings on a Dictaphone were transferred to the University of York's filestore within two days, and then deleted from the Dictaphone. Whenever the Dictaphone included interview data, it was either on the researcher's person (travelling between the prison and university) or in a locked drawer in the university, to which only the researcher had access. At the request of HMPPS, an encrypted password protected Dictaphone was used.

When participants gave permission, an anonymised written transcript of the interview was submitted to the UK Data Service, with limited access to other accredited researchers permitted. In line with University of York policy, the UK Data Service will store this anonymised information for a maximum of 10 years.

Ethical approval

Ethical approval for the research was complicated by the requirement for three bodies (the National Health Service, Her Majesty's Prison and Probation Service and the University of York) to review the research proposed in detail. Although these processes were bureaucratic, they reflected real concerns that participants should be able to make informed decisions about consent, that the risks to participants (and the researcher) should be minimised and as far as possible, and that the limitations on anonymity and confidentiality should be understood.

One of the key descriptions of ethnography used by O'Reilly (2012) is that it is "iterative-inductive" and as such the design of a research project changes and evolves as fieldwork progresses. This is challenging in the context of a research climate which demands ethical approval for research projects in advance. The nature of the chosen research questions was such that fieldwork needed to be undertaken in hospitals as well as prisons, compounding the challenge by requiring ethical approval from the NHS Health Research Authority whose processes are primarily intended for clinical trials. Writing about conducting ethnographic research in healthcare settings, Murphy and Dingwall (2007) state:

> *Informed consent in ethnographic research is neither achievable nor demonstrable in the terms set by anticipatory regulatory regimes that take clinical research or biomedical experimentation as their paradigm cases. (p.2223)*

Although processes exist within the Health Research Authority's framework for research projects to be subsequently amended, this is not straightforward and can further delay research plans. Instead, there seems to be an assumption inherent in the process that all possible scenarios will be known in advance. With this comes an assumed relationship to the research participants; they are to be the subjects, not the co-creators of research knowledge. This echoes Murphy and Dingwall's (2007) suggestion that the power relationships between doctors and research participants/patients and ethnographers and their participants are very different. They argue the potential harm of ethnography to participants is considerably different, and less, than the potential harm to participants in the biomedical experiments for which such ethical review processes were originally established.

In addition to the NHS Health Research Authority, ethical approval was also required, and obtained, from HMPPS and the University of York's Economics, Law,

Management, Politics and Sociology ethics committee. Unsurprisingly, there were occasions when the expectations of the three ethics committees were incompatible, for example with regard to what contact information should be included in the participant information sheet. HMPPS was anxious contact details for external people, such as academic supervisors, must not be included on participant information sheets; the NHS expected these details would be available on the PIS; the University wanted email addresses only, but HMPPS rules prevent prisoners having access to email. Instances such as this resulted in a much longer PIS than had been intended, something which was far from desirable given not all prisoners are confident readers, and may actually have reduced the likelihood of participants giving fully informed consent.

Hammersley (2009) questions whether any ethical committee has the expertise to make a reliable judgement on any particular research project:

> *There are good reasons to believe that ethics committee are incapable of making sound — and, even less, superior — ethical decisions about particular research projects. Given this, the exercise of their authority will not improve the 'ethical quality' of social science research (p.212)*

This was demonstrated during the process of obtaining approval for the research from the two separate NHS hospital trusts involved. One NHS Trust subjected the proposal to a further ethical review after the Health Research Authority's Research Ethics Committee had approved it, and asked questions about the aspect of the fieldwork that would be conducted within the prison, not the hospital, which revealed the committee members' ignorance of prison matters.

3.11 Conclusion

The research strategy chosen was the one felt to be most appropriate to the research questions and the epistemological and theoretical framing of the research. Ethnographic methods were ideal for collecting data which provided a rich picture of the social worlds of the research participants.

The subject matter and location of the fieldwork raised a number of important practical and ethical considerations, which could be addressed by drawing on the experience of other prison researchers, including others with experience of insider research. There were, however, also limitations imposed by the process of gaining approval from three ethics review committees, including the impossibility of

designing a methodology that was truly iterative-inductive as O'Reilly (2012) suggests ethnography should be. Gaining ethical approval from three ethics committees was a lengthy process, and resulted in some less than ideal outcomes, such as a long participant information sheet. It was however important at the outset to recognise, if only to oneself, that no project could achieve ethical 'perfection' and to identify possible solutions to anticipated problems, such as the loss of capacity to consent or the impossibility of guaranteeing anonymity or confidentiality in all circumstances. Other compromises were necessitated by the fieldwork locations, including using semi-structured interviews. Resolving these difficulties in the design of the methodology was however essential given the growing importance of the research questions in the light of the increasing number of prisoners dying from natural causes and, as shown in the literature review, the paucity of existing studies which had addressed these challenges to provide research on this topic.

Chapter 4: Constructing the carceral geography of death and dying: places, spaces and rules

4.1 Introduction

To be in prison is to be in a place apart, separate from the community and family, a place which both looks different to other places and is subject to different social and actual rules. Closed prisons are markedly different physical spaces where the architectural and design features are characteristically those of incarceration. Experiences within prison, including dying, are inevitably heavily marked by the peculiarities of the physical location. What is coming to be known as 'carceral geography', defined as "geographical engagement with the spaces, practices and experiences of confinement" (Royal Geographical Society, 2018), offers new ways to consider the emplaced and embodied experience of imprisonment. Originating as a part of human geography, the concept of carceral geography as applied by social scientists such as Jewkes and Moran to the punitive turn within western societies suggests the physical environments of prisons both reflect policy and mould experiences of incarceration (Jewkes, 2017; Jewkes and Moran, 2017; Jewkes, Slee and Moran, 2017; Moran, Jewkes and Turner, 2016; Moran, 2015; Baer and Ravneberg, 2008).

To understand how prison changes the experience of dying, it is necessary to consider the physical environment — the carceral geography — surrounding death, as well as the rules governing actions and interactions within this environment. This chapter will consider the four locations within the prisons studied associated by staff and prisoners with death and dying. It will consider the extent to which carceral geography influences responses to prisoners dying from natural causes and how these deaths in turn impact on places and spaces. Having defined the relevant spaces, it is then important to consider the circumstances in which dying prisoners move between these spaces and what is understood by others from changes to their physical location. Lastly, attention will be turned to the rules governing these spaces, and the impact of prison rules in making these spaces different from those 'outside' in terms of responses to dying prisoners.

As will be seen, compassionate release, allowing a terminally ill prison to die at home, outside of prison custody and free, is rare. As a result, dying prisoners remain imprisoned, separated from the wider community and subject to prison rules. It will be shown that within the prison, dying prisoners may be further segregated. In this regard the prisons studied were seen to be highly segmented spaces. Dying

prisoners could typically find themselves in one of four different locations. Each of these locations will be considered in turn: the prison wing, the prison healthcare centre, the palliative care suite within this if there was one (as at HMP Wakefield), or in a hospital outside of the prison. At HMP Leeds, prisoners might also be located in a hospice, in similar physical circumstances to being in hospital, and again still in prison custody. The mobility of prisoners between these four spaces will also be discussed. As will be seen, the location of a prisoner might change during the course of the dying trajectory, particularly as they passed through what Glaser and Strauss (1968) refer to as 'transitional statuses' and 'critical junctures'. Consideration will be given to where the authority to determine the location a dying prisoner resides. The events which in the prison could serve as indicators of when to move a dying prisoner will be explored, together with how prison personnel constructed their understandings of when and why the location of a terminally ill prisoner changed. Understandings of a prisoner's place in the 'dying trajectory' (Glaser and Strauss, 1968) will be seen to be derived from their location.

Having discussed the four locations within prison custody relevant to the dying prisoner, a fifth, rarely used 'space', compassionate release, will be considered. As will be seen, although compassionate release remains a possibility within the prison rules, prisoners and prison staff did not expect it to be granted to terminally ill prisoners. The reasons why the physical locations associated with compassionate release, of going 'home', or to a hospital, hospice or care home without the trappings of prison custody, were thus inaccessible to most dying prisoners will be discussed.

The experience of being in the four locations within prison custody, or of seeking access to locations outside of prison custody, is governed by the large number of rules, regulations and guidance which control prison regimes and serve to translate power down the prison hierarchy. How the rules, regulations and guidance governing prisons impact on the experience of dying is discussed, particularly with reference to the limitations on compassionate release.

4.2 The physical environment of the prison wing

The vast majority of prisoners in both prisons studied were accommodated in cells on prison wings. Although other locations are relevant to some prisoners in certain circumstances, including serious or terminal illness as well as for their own protection or when segregated as further punishment or to protect others, the prison

wing is the main unit of accommodation for prisoners and a key component of prison architecture. As Jewkes and Moran (2017) argue, the architecture of prisons is a physical expression of the penal philosophy of their time. Built largely in the Victorian radial style, HMP Wakefield and HMP Leeds are imposing stark buildings full of long landings, narrow stairs, high ceilings, hard surfaces, artificial lighting and small cells. They have inherited their architecture from an earlier time, but it continues to shape life on the prison wing. The two prisons studied are similar in design to HMP Pentonville, described by Jewkes and Moran (2017) as giving "full expression to the Victorian obsession with discipline, certainty, and systematic uniformity" (p.546) and reflecting the new objectives of imprisonment at the time — deterrence and repression. As city centre prisons, they were built "as looming warnings of the consequences of crime" (Crewe, 2009, p.1) and although newer buildings have been added on both sites, they retain an aesthetic which reflects their Victorian origins. HMP Wakefield and to a lesser extent HMP Leeds are sites marked by very obvious security features: strong high walls, towering wire fences, barbed wire, patrol dogs and surveillance cameras, which Jewkes and Moran (2017) suggest reflects the emphasis of the new penology on security and containment.

Turner and Peacock (2017) argue that inside the prison, the design, layout and facilities of prisons are intended for younger, healthier prisoners and that this adversely affects what is possible in terms of care for older or frailer prisoners. They identify a number of practical difficulties arising from the prison setting including cells too small for hospital beds. In keeping with this, cells on the Victorian-era wings in each of the prisons studied were small and cramped, with limited facilities. At both prisons there were in-cell toilets, as is normal in prisons in England and Wales, but only communal shower facilities, with small screens to maintain privacy. Thick pipes running under the cell windows provided the heating, and were put to a variety of uses, including drying laundry, but the temperature could not be controlled by the cell occupant and some landings were colder than others. In all cells, there was a call bell by the door to summon help. Bedding was provided by the prison but often regarded as too thin and inadequate to provide warmth.[10]

Adaptions were made to the physical environment of the wings in HMP Wakefield to try to meet the needs of prisoners who were unwell, frail or disabled. Lifts had been added to two wings, although they were often out of order for long periods of time.[11]

[10] Fieldnotes, Wakefield, 15/12/2017, 7/2/2018
[11] Fieldnotes, Wakefield, 16/5/2018, 14/11/2017

As is usual in high security prisons, cells were single occupancy. Some, nearer the Cleaner's Office, had deliberately lowered doorsteps. These cells often accommodated prisoners with mobility issues who would benefit from the lack of a doorstep, as well as those who were vulnerable for other reasons and who staff wanted to be able to watch more closely. The need for these cells often exceeded their supply. Less structural changes were also made to the physical environment. The prisoners who ran the stores tried to ensure elderly and frail prisoners got extra mattresses and blankets.[12] In one instance a terminally ill prisoner, Eddie, was accommodated on the wing at HMP Wakefield. A doorbell was placed near his bed, with a receiver in the Cleaner's Office to alert officers, so he would not need to undertake the struggle to reach the normal cell bell to call for assistance. This had little impact on the regime; officers reported that it only rang when a colleague checked it worked each morning.[13] More significant was the way in which the presence of a terminally ill prisoner on the wing could change usual practices for locking and unlocking cell doors. In the case of Eddie, officers on the wing left his cell door unlocked for lengthy periods, acknowledging this was a result of his diagnosis and because it would facilitate his care. In this way, his condition materially altered his immediate physical environment, although by this time he was too frail to leave his cell unassisted, even when the door was unlocked.

In HMP Leeds, the cells were double occupancy. On F wing, where a number of elderly or disabled prisoners were accommodated, the frailer prisoners tended to occupy the lower bunk. This wing was three landings high, with a central corridor and cell doors the length of each landing. The ground floor landing was known as the '3s':

> *Most of the practicalities — servery, laundry, PID desk, phones — are on the 3s. The CM who first showed be round said that he was supposed to put prisoners on Basic on the 3s, so they were less likely to jump on the netting — the metal mesh that covers the open spaces between landings. In practice, he needs to put the elderly, wheelchair users on the 3s so they can access what they need. There are two sets of stairs on the wing; one goes straight up from the middle of the landing, the other is at the end of the landing and has a right-angle bend. There is no lift.*[14]

[12] Fieldnote, Wakefield, 15/12/2017
[13] Fieldnote, Wakefield, 30/1/2018
[14] Fieldnote, Leeds, 20/2/2018

Staff on this wing were thus trying to balance the needs of elderly, frail and disabled prisoners with those who were vulnerable in other ways or likely to present other challenges, but their options were limited by the physical environment. On this wing there were regularly three or four prisoners using wheelchairs, and I witnessed two visually impaired prisoners using white canes to get around.[15] One prisoner spoke about his concerns for the wheelchair users, who had to leave their chairs on the landing outside their cells, a practice observed elsewhere by Mann (2012) who suggests it may be a breach of the Disability Discrimination Act. The prisoner said he had asked the officers if the cell doors could be widened, but had been told the walls were load-bearing and no adjustments could be made.[16] During the research, F wing in HMP Leeds did acquire a lift to allow less mobile prisoners to access the exercise yard, although there was still no lift between landings.[17]

The physical environments of the prison wings in both prisons studied thus presented several challenges to the elderly, frail or disabled prisoners accommodated there. Whilst some adaptions were made, such as lowering doorsteps or introducing cell bells nearer to the bed, prison officers and prisoners were aware of the limitations of the physical environment. Whilst often reflecting social care needs, the challenges witnessed are indicative too of the difficulties faced by prisoners who were nearing the end of life on the wings. The limitations of the physical environment of the prison wing resulted an earlier conception of the purpose and population of a prison which found its manifestation in narrow landings, steep metal stairs, cramped cells and narrow doorsteps. This was one of the factors contributing to the expectation, discussed below with regard to the spatial ordering of dying prisoners, that people with such needs would be relocated to the prison healthcare centre.

4.3 Prison healthcare centres

The physical environments of the healthcare centre in HMP Wakefield and of H3 in HMP Leeds, used for prisoners with social, physical and mental health needs, reflected many of the characteristics of the wider prison environment. In both areas, as in the prisons where they were located, windows were barred, and in HMP Wakefield they were also covered by wire grilles.[18] There were locked doors and gates throughout the healthcare centres in the same styles as elsewhere in the

[15] Fieldnotes, Leeds, 15/2/2018, 19/2/2018
[16] Fieldnote, Leeds, 25/6/2018
[17] Fieldnote, Leeds, 26/6/2018
[18] Fieldnote, Wakefield, 27/10/2017

prison. However, there were some differences. Whilst retaining the characteristics of a prison, both HMP Wakefield's healthcare centre and H3 in HMP Leeds were physically and symbolically spaces apart from the other areas where prisoners were accommodated. Cells in these spaces were single occupancy, something very rare on the wings at HMP Leeds and slightly bigger (in the case of some rooms in HMP Wakefield, originally built as wards, considerable bigger).[19] Whilst on the wings landings were used for association, in contrast, each healthcare centre had a 'dayroom', where some prisoners spent their time. Attempts had been made to enhance these and other communal spaces with pictures on the walls.

In HMP Leeds, the apartness of H3 was most noticeable in the way it operated a slightly different regime to the rest of the prison, responding to the perceived needs of the prisoners. It was described by staff as more relaxed and characterised by mutual respect between staff and prisoners.[20] There were regular games of dominoes, often involving an officer who would patiently remind prisoners when it was their turn or try to catch the eye of the score-keeper if he had forgotten to add on points.[21] Nowhere else were staff observed playing games with prisoners. H3 was often conceptualised by staff as apart from the prison. Some of the nursing staff and a prison officer who spent considerable time in H3 referred to the other areas of the prison as 'the jail', or as 'downstairs'.[22] H3 was also the only place in the prison where those convicted of sex offences and other prisoners mixed.[23] It was significant that one of the officers regularly working in H3 expressed a wish to differentiate the dayroom from a hospital institution, saying the murals had been put on the walls "because it's too clinical for me up here". Whilst he felt the need to avoid H3 feeling like a hospital, he did not seek to make it different from the prison.[24] It may be he felt this was neither needed or desirable.

It could be argued H3 was a 'free place' as suggested by Goffman (1961), meaning a geographical location associated with more licence for prisoners. Goffman describes these as places with a notably lower population density, characterised by a sense of peace, as H3 was, "physical spaces in which ordinary levels of surveillance and restriction were markedly reduced" (1961, p.205). However, Goffman argues staff "did not know of the existence of these places, or knew but

[19] Fieldnote, Wakefield, 23/10/2017
[20] Interview 3, Leeds
[21] Fieldnote, Wakefield, 27/2/2018
[22] Interviews 2 & 3, Leeds
[23] Interview 3, Leeds
[24] Interview 3, Leeds

either stayed away or tacitly relinquished their authority when they entered them" (1961, p.205). This was clearly not the case in H3 at HMP Leeds and certainly not in the healthcare centre at HMP Wakefield, which will be discussed in more detail below. Despite the regime on H3 being described as more relaxed, there were still obvious restrictions on prisoners' movement and access to activities. The physical environment was clearly marked as a prison. In the dayroom itself, there were notices reminding prisoners of their status, including posters for Veterans in Custody and notices to have recorded on C-Nomis (the database of the prison population) if they were a traveller or gypsy.[25]

The situation is more complicated than Goffman's outline. Crewe et al. (2013) suggest spaces such a chaplaincy or education classes within a prison can be 'emotion zones' where deviations from the usual 'feeling rules' of a prison can occur and which provide temporary relief from the realities of the wing. They argue these intermediate zones needed to be cultivated, usually be staff, in order to reflect a different construction of the prisoner. This seemed to be the case in H3 in particular. Far from staff being unaware of the differences in these spaces, the physical environment of H3 was marked by attempts by officers and healthcare staff to reduce the restrictions on prisoners, responding to their serious or terminal illnesses, originating in the different requirements and perceived risks of a population with pronounced social care needs. It is useful to think of H3 as a place where the boundary between 'inside' and 'outside' became slightly less distinct (Baer and Ravneberg, 2008). The space retained an institutional feel[26] but in subtle and sometimes shifting ways differed from other areas of the prison.

At HMP Wakefield, the healthcare centre was also a place apart, but not in the same way as H3 in HMP Leeds. It was physically apart, occupying a separate, more recent building not connected to the main prison, but the regime operating there differed very little from the main prison. This physical distance from the main accommodation wings was equated by prisoners to a social distance.[27] Being resident in the healthcare centre was seen as an isolating experience. Because of its location, in order to access the healthcare centre, prisoners had to be accompanied by a member of staff out of the main building, across the yard and through a locked gate in a tall wire fence. Although staff said they would try to get a prisoner's friends over to see him, there were problems with this in practice including

[25] Fieldnote, Leeds, 6/3/2018
[26] Fieldnotes, Wakefield, 27/10/2017, 5/12/2017; Leeds, 25/6/2018
[27] Fieldnote, Wakefield, 27/10/2017

inadequate staffing levels, especially if the friends were category A prisoners.[28] Chaplains explained their daily visits to the building as being because prisoners there were "isolated from the main prison", [29] reinforcing the sense that healthcare was a place apart. In contrast to HMP Leeds, at HMP Wakefield there was very little interaction between prisoners and officers in the healthcare centre, with the exception of the prisoner who worked as an orderly. The in-patient prisoners rarely acknowledged the presence of anyone else.[30] Here there was a notice saying "Offenders are not to leave the dayroom without first seeking permission from a member of staff",[31] with the underlining seemingly adding emphasis to the status of the individual. At HMP Wakefield, prisoners who had previously spent time or visited the healthcare centre described it as depressing and unclean.[32] Healthcare staff were aware of this reputation.[33] The current and historic presence of terminally ill prisoners in the healthcare centre in this prison did not seem to have impacted on the regime, culture or relationships of the centre in the same way as the social care needs of prisoners in H3 in HMP Leeds, at least as far as prison officers were concerned.

Prison healthcare centres, the second locations associated with terminally ill prisoners, were thus spaces apart from the main prison, differing in noticeable ways from the prison wings discussed above. The sense of apartness was stronger in H3 in HMP Leeds than in the healthcare centre in HMP Wakefield, and illustrated by changes in the décor and differences in the relationships between prison officers and prisoners. At HMP Wakefield, the physical difference between the healthcare centre and the wings was equated to a social distance, but the regime differed only very slightly. Healthcare centres were not 'free places' (Goffman, 1961) but instead more akin to 'emotion zones' (Crewe et al., 2013) where staff cultivated an intermediate zone where different feeling rules could apply, or perhaps in the case of H3, spaces where the boundary between 'inside' and 'outside' the prison could blur very slightly (Baer and Ravneberg, 2008).

[28] Fieldnote, Wakefield, 19/12/2017, 18/12/2017
[29] Fieldnote, Wakefield, 3/11/2017
[30] Fieldnote, Wakefield, 5/12/2017
[31] Fieldnote, Wakefield, 27/10/2018
[32] Fieldnote, Wakefield, 27/10/2018
[33] Interview 12, Wakefield

4.4 Prison palliative care suites

Of the two prisons visited, only HMP Wakefield had a designated palliative care suite. Senior healthcare staff at HMP Leeds had used a large room at one end of H3 for this purpose and had recently been given permission to adapt it for more permanent use as a palliative care suite. The rooms used as palliative care suites had a very practical advantage over other cells in the healthcare centres. Typically, cells had solid doors, with flaps on the outside at approximately chest height that could be opened either downwards or sidewards in order to see the prisoner inside. At times during the day and night, the prison regime required these doors would be locked, but where there was also a metal gate across the door, as in the rooms selected for the palliative care suites, the gate could be locked instead and the door left open. This made it easier for nursing staff do visual checks on the occupant and enabled them to hand over medication without the considerable inconvenience of getting a door unlocked whilst the prison was in patrol state. In both prisons, there was a willingness to leave the door of the palliative care suite open when death was close, even overnight, in marked contrast to what was normal in the prison environment.

Healthcare staff in HMP Leeds felt the room they had available was unsuitable without further development. They had had to make their case to prison governors since the room was also in demand for use with other groups of prisoners and had emphasised adapting the room would not be expensive. It would not be a luxurious space.[34] At HMP Wakefield a project to redecorate the palliative care suite began at about the same time as the fieldwork, with prisoners planning and creating new soft furnishings and art works intended to improve the appearance of the space. Making the palliative care suite different from the prison environment was an important motivation for the healthcare staff at both prisons. The creation of these new spaces was a significant way in which deaths from natural causes had changed the fabric of the prison. Part of creating and trying to improve the appearance of the palliative care suites was an attempt to make the physical environment around the dying prisoner less symbolic of prison, to make it less 'inside':

> *So, I think as well, when we get this suite decorated, there's so many great things happening, that will be so much nicer. You'll forget that you've got these*

[34] Interview 1, Leeds

bars around you and it will just be "this is a proper hospice". I'm looking forward to that.[35]

For this nurse, "a proper hospice" environment was better suited as place to die than the prison, and the redecoration of the palliative care suite provided an opportunity to envision the dying individual in a setting which better matched her professional expectations.

At HMP Wakefield, nursing staff knew prisoners referred to the palliative care suite as 'death's waiting room' or the 'departure lounge' and wanted to counter this reputation.[36] Prisoners working in the Co-Mission-D Arts group within the prison's education department created pictures, installations and soft furnishings for the suite. The group visited the existing palliative care suite, describing it as "cold and dirty", "empty", "clinical" and "ugly". Those who had spent some time there said it was "drab". Reflecting on what they would want for a dying prisoner and his family, the group chose the theme of a Japanese garden, wanting to create somewhere "calm and comfortable", "homely, warm, safe" and "pleasant".[37] A fieldnote at the conclusion of the project describes the room, renamed as the 'Lilypad' to bring together the ideas of a garden and a 'pad' or prison cell:

It feels notably softer and more welcoming that my last visit. The most striking thing is the bed, with a shiny grey and white striped single duvet cover and a cushion with a matching background print overprinted with a colourful lotus flower. Two further cushions also stand out — the bamboo striped one and a plainer grey one — on two blue high-backed chairs. Whilst the chairs look institutional, the cushions look welcoming. There are also curtains — cream and billowing in the wind — at both windows. The soft furnishings stand out. They are unexpected, less institutional than I'd expect. The colours are subtle, but colours all the same.[38]

At HMP Leeds, soft furnishings were also regarded as important in creating the transformation:

At the moment it's a very clinical room, it's just got a bed in, the aerial for the telly is appalling so it's not, it's not how it could be… so we're going to get

[35] Interview 12, Wakefield
[36] Fieldnote, Wakefield, 20/10/2017
[37] Fieldnote, Wakefield, 13/12/2017
[38] Fieldnote, Wakefield, 14/6/2018

some nice furnishings stuff like that, and we're going to make hopefully a really good palliative care suite.[39]

The redecorated palliative care suite at HMP Wakefield served to highlight the harshness and monotony of the usual prison environment. Baer and Ravneberg (2008) highlight the role furniture can play in indicating 'inside' and 'outside'. Soft furnishings were a rarity in the prison setting and their presence in the palliative care suite is both a surprise and a direct physical response to concerns about prisoners who are dying and their families. They bring in a representational meaning which feels very alien from what is normally experienced in the prison. The effect the cushions had on one of the prisoners involved in the project at HMP Wakefield was striking. He kept picking up a cushion, and squeezing it, the softness seeming to be unusual.[40] The same prisoner recounted finding softness on a visit to an outside hospital, placing a value on material softness which points to its rarity in the life of a long-term prisoner:

And they had these chairs that were so comfortable, you kinda sank back into them and could really chill. That's how he imagines heaven, not the thin prison mattresses. As he talks about the chairs, he leans back and closes his eyes.[41]

Burles et al. (2016) suggest prison regimes are at odds with the concept of a good death, which is defined as characterised by comfort, control and closure. Here it is the comfort that is being emphasised, the importance of a physical softness which is antithetical to prison life and to the punitive harshness of prison architecture and design. Some prisoners could find this unsettling. One, having seen the completed palliative care suite in HMP Wakefield said: "luxury items like these are not what someone wants who's dying in the hostile environments of prison".[42] Instinctively, he seemed to be aware of the disruptive symbolic role of the soft furnishings which had been added to the palliative care suite, hinting at a more luxurious place, softer than the starkness of prison.

Nursing staff were also affected themselves by the physical environment, with one nurse saying when the suite redecoration was finished: "that will be nice for us, because it will be that proper hospice environment, so we can switch off".[43]

[39] Interview 10, Leeds
[40] Fieldnote, Wakefield, 21/3/2018
[41] Fieldnote, Wakefield, 11/10/2017
[42] Fieldnote, Wakefield, 29/5/2018
[43] Interview 12, Wakefield

She talked about 'switching' off several times, suggesting this was the technique needed to help her nurse prisoners as she wanted to, not overly aware of the reasons why they were in prison or thinking of them exclusively as prisoners. She identified that her experience of the physical environment in which prisoners are dying, when it is changed to look less like a prison, will assist her in her construction of the prisoner as a patient. The contrast between identifying the individuals as 'prisoners' and 'patients' will be discussed in the next chapter.

The third location associated with dying and deaths from natural causes in the prison, the palliative care suite, thus demonstrates a deliberate effort to alter the physical environment, to introduce elements symbolically differentiating it from the prison. These efforts are motivated by concerns for the dying prisoner and their family. The differences in the physical environment of the palliative care suites have practical relevance, such as facilitating medical care by leaving doors unlocked. However, what is most striking is the psychological impact of introducing soft furnishings into the space, highlighting the absence of softness from the usual environments of the prison, including the prison wing and the prison healthcare centres more generally.

4.5 Hospitals and hospices

Prisoners could be accommodated on the prison wing, in the prison healthcare centre or in a palliative care suite within the prison, but when seriously or terminally ill prisoners required medical treatment beyond what was available within the prison, they were transferred to outside NHS facilities. In the case of HMP Leeds, there were also occasions when a terminally ill prisoner had been transferred to a local hospice as they neared the end of life.[44] When medical conditions required prisoners to be taken to a hospital or hospice outside of the prison, they would still not be dying in the same environment as other people. In these circumstances, the prisoner remained in the custody of the prison, and although the hospital or hospice settings were not carceral, visible signs of the prison were transported into the hospital with them. Known by the de-personalising term of a 'bedwatch', the accompaniment of the prisoner by prison officers brought into the hospital the trappings of incarceration, including prison uniforms, prison equipment and often the physical restraints of handcuffs or an escort chain. In this respect, the requirements of their ongoing imprisonment impinged on the physical environment of the hospital

[44] Interviews 1, 2, 3, & 10, Leeds

bedside and whilst the prisoner was materially outside the prison they were simultaneously representationally inside. This can be understood as another way in which the ‘inside’ and ‘outside’ (Baer and Ravneberg, 2008) of prison become entangled.

As part of the fieldwork, four ‘bedwatches’ were observed, in St James’s Hospital, Leeds and Leeds General Infirmary. One of these was on a shared ward, with the curtain permanently closed around the bed. The others were in individual side rooms, an arrangement which officers and governors said they preferred.[45] These spaces were, however, changed in their appearance when accommodating a prisoner. Typically small, the presence of two officers, (usually requiring an extra chair), their personal bags and the escort bag containing equipment required by the prison service ‘rules’, specifically PSI 33/2015,[46] meant the bedside felt very crowded.

All of the prisoners observed in hospitals during the fieldwork were distinguishable by the escort chain they wore, looped over bed rails or hanging beside the bed before attaching to a prison officer sat in a high backed chair by the head of the hospital bed.[47] In other parts of the hospital, these chairs would have been used by patients, having a change of position from lying or sitting in bed, but the need for the officer to be within a chain’s length of the prisoner removed this possibility. When conversation flagged, the most conspicuous sound was that of the escort chain, banging against the metal hospital bed as the prisoner or officer adjusted position.[48] The use of restraints is discussed further in the chapter five.

The close proximity of officers and prisoners for prolonged periods of time might be expected to change their relationships, but there was no indication from observations or from interviews that this was the case. The level of interaction between officers and prisoners seemed to vary, but on all the observed ‘bedwatches’ the radio or TV was playing if the staff wanted it on. One prisoner complained the officers previously with him had not let him watch programmes he wanted.[49] Another was seemingly deliberately disengaging himself from the officers present, ignoring their choice of TV.[50] Sometimes officers and prisoners spoke to

[45] Fieldnote, Wakefield, 19/7/2018
[46] Handcuffs, copies of the Person Escort Record, Risk Assessment and Escape pack, a mobile phone, first aid kit and plastic cutlery for the prisoner’s to use
[47] Fieldnotes, Leeds, 26/6/2018, 10/7/2018; Wakefield, 19/7/2018
[48] Fieldnotes, Leeds, 26/6/2018, 10/7/2018; Wakefield, 19/7/2018
[49] Fieldnote, Wakefield, 19/7/2018
[50] Fieldnote, Leeds, 10/7/2018

each other, but officers more frequently spoke amongst themselves.[51] On one of the observed 'bedwatches', officers frequently interrupted the prisoner when he spoke to me, seemingly vying for my attention or perhaps assuming he was of less interest.[52]

It was the presence of escort officers forming the 'bedwatch' that was key to the hospital or hospice bedside being marked as part of prison custody. By providing surveillance over the occupant of the bed, they introduced into the hospital or hospice a function more readily associated with imprisonment. Foucault (1991a) suggests the underlying differences between prisons and the hospitals were less marked than might be expected, perhaps explaining how readily the transformation of the hospital bedside into a place of prison custody could be accomplished. Both are institutions where Foucault (1991a) argues disciplinary power is used, where bodies are observed and moulded into the correct forms of behaviour. The similarities in how disciplinary spaces were structured and the shared properties of prisons and hospitals that Foucault identifies perhaps explains the ease with which the hospital bedside became a carceral space.

At the very end of life, it was sometimes possible for the characteristics of prison to be diminished in the physical environment of the outside hospital or hospice. Officers accommodating prisoners going from HMP Leeds to the hospice were reported to be usually not in uniform.[53] At the hospice, terminally ill prisoners were accommodated in private rooms, although one prison healthcare professional said they were typically put in the end room, furthest from other patients, because of the stigma associated with having an escort.[54] In the case of Iain, who had received a terminal diagnosis between conviction and sentencing, an officer spoke about accompanying his wife when he was close to death in hospital. With no side room available, he was in the middle of a six-bedded ward, with the curtains pulled around him. As a family liaison officer, the officer was not in uniform and uniformed prison officers had moved away from him out of respect, keeping nearby in case needed. He was therefore less identifiable as a prisoner. Other patients in the ward were very disruptive, including one man who repeatedly and loudly said he wanted to die. Whilst the environment was far from ideal, it was in many ways less marked by prison than other deaths in custody. When his end came, however, his wife had

[51] Fieldnote, Wakefield, 19/7/2018
[52] Fieldnote, Wakefield, 19/7/2018
[53] Interviews 10 & 2, Leeds
[54] Interview 10, Leeds

briefly left the ward, and it was two prison officers, one in uniform, who were sat with him.[55]

The fourth location associated with terminally ill prisoners, hospitals and hospices, whilst physically outside the prison, becomes closely associated with the prison by the presence of prison officers performing a 'bedwatch'. The carceral space moves with them and the prisoner they are accompanying, bringing the symbolic and practical changes that result from the use of restraints, the presence of uniformed prison staff and the interactions between the prisoner and the prison officers originating in their relationships within the prison.

4.6 The determiners of location

Within the physical environments realistically available for the dying prisoner, the prison wing, prison healthcare centre, palliative care suite (if one existed) and 'outside' hospital or hospice, the fact of imprisonment played a significant role in location. Dying prisoners had limited say and could not determine their physical place within the prison. A terminally ill prisoner might be moved between the four possible locations during the course of his illness. However, his mobility between these spaces was not within his control, nor was there a single trajectory through these locations. Instead, mobility was imposed upon prisoners by their physical condition, but also by custom, cultural expectation, prison rules and the exercise of authority by senior prison staff and others. Part of the discipline associated with the prison regime was achieved by governors and officers determining where any prisoner was located, demonstrating an understanding, as Foucault states, that "discipline proceeds from the distribution of individuals in space" (1991a, p.141). This applied to dying prisoners too, although the fact of their dying meant other staff, especially healthcare professionals, played a role in decisions about their location. As will be seen, there was an established presumption that seriously or terminally ill prisoners would be located in the prison's healthcare wing. Prisoners known to be terminally ill might exceptionally be housed on wings as their illness advanced; the circumstances determining when this would happen are discussed below. This was unusual, and is one of the ways in which the experience of more frequent deaths from natural causes in the prisons studied was changing the regime, making new practices acceptable.

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[55] Interview 16, Leeds

The case of Neil, a prisoner who had died at HMP Wakefield before the research began, was discussed by staff and prisoners alike. Unusually, he had arrived at the prison after a terminal diagnosis, transferred to be nearer family after receiving a prognosis of one year to live. Once at HMP Wakefield, his progression through the physical spaces of the prison was typical of the expected trajectory of a terminally ill prisoner. Initially he was accommodated on the prison wing, but was then moved to the healthcare centre as soon as he started to experience weakness on one side and a loss of balance. From there, he was moved to the palliative care suite after four weeks, where he died eight weeks later (Prison and Probation Ombudsman, 2017). This was regarded as a typical pathway.

There were exceptions. During the fieldwork, a prisoner at HMP Wakefield with a terminal diagnosis, Eddie, was accommodated on one of the wings. He had initially been moved to the healthcare centre but was returned to the wings after expressing a strong wish to be with his friends and remained there even when he had very limited mobility. His case illustrates several factors in the spatial arrangement of dying prisoners. On one occasion, an officer on his wing told me they were moving a prisoner so Eddie could be accommodated closer to the officers' base and other facilities in the prison. I asked if Eddie was accepting of this move, knowing how much location mattered to him, and was told he would have to be.[56] There was an assumption that as a prisoner, he had no choice. The powers of officers in this respect were, however, not total. Overhearing the prison officer say this to me, another officer challenged him, saying that the Senior Officer had spoken with Eddie and this was not going to happen, encouraging the first officer to check the records. The officer's response was that it could wait until the SO was back;[57] the SO was therefore seen as having the crucial say, but significantly, not the prisoner. The final authority on a prisoner's location was given to the Governing Governor. In HMP Wakefield, the Governing Governor was perceived as previously having been opposed to prisoners staying on the wing if they were ill, to the extent that when an SO returned from leave to find Eddie on the wing, he checked the Governing Governor had approved the arrangement.[58] The Governing Governor was similarly crucial in decisions about the location of dying prisoners at HMP Leeds, although healthcare staff there said the prisoner might be then given options.[59]

[56] Fieldnote, Wakefield, 7/12/2017
[57] Fieldnote, Wakefield, 7/12/2017
[58] Fieldnote, Wakefield, 14/11/2017
[59] Interview 1, Leeds

Healthcare professionals within both prisons determined when needs were too complex for the medical services available in the prison. At HMP Leeds, prison officers regarded decisions about when to send a prisoner to outside hospital or hospice as resting with healthcare staff.[60] Healthcare staff at HMP Leeds did sometimes feel under pressure not to send someone to outside hospital because of the cost implications of a 'bedwatch'.[61] They had used concerns about costs to persuade the prison authorities to let them move a prisoner to the room intended as a future palliative care suite, arguing that if he wasn't in a room without the usual cell door, he would have to go to hospital with a costly 'bedwatch' ensuing.[62]

Terminally ill prisoners in general had very little say about where they were located, to the extent that when they expressed a desire with regard to location which was respected, this was noteworthy. Eddie was not historically unique in this regard, but he was unusual, such that the fact he was "being allowed" to stay on the wing was raised regularly by both staff and prisoners,[63] and often attributed to his perceived stubbornness.[64] Arguably, he only succeeded because he was also liked. Staff described him as a "decent" prisoner and wanted to meet his wishes.[65] They saw the arrangement as working well because he was popular and had friends willing to provide care.[66] Eddie's placement on the wing did however, come with an assumption that at some point his wishes would be overturned. Prison officers, SOs, healthcare staff and the governor involved in his case all said that at some point he would have to be moved.[67] One of the nurses thought they would not be able to persuade him, but still saw it as inevitable he would be taken to the healthcare centre to die.[68] Only so much disruption of the expected norms of location for a dying prisoner could be tolerated, even if the prisoner was well liked and respected.

4.7 Indicators of when to move a dying prisoner

Given that prison staff, including the Governing Governor, healthcare staff and senior officers, determined the location of a seriously or terminally ill prisoner, and their mobility between the locations associated with dying and death, it is important

[60] Interview 9, Leeds
[61] Interview 12, Leeds
[62] Interview 10, Leeds
[63] Fieldnotes, Wakefield, 13/12/2017, 7/11/2017, 7/12/2017, 30/11/2017, 23/11/2017; Interview 15, 5, 6 & 12 Wakefield
[64] Fieldnote, Wakefield, 15/12/2017
[65] Fieldnote, Wakefield, 30/1/2018
[66] Fieldnote, Wakefield, 14/11/2018, 14/11/2017(b), 1/2/2018, 19/12/2017, 23/11/2017
[67] Fieldnotes, Wakefield, 30/1/2018, 23/11/2017, 2/11/2017, 14/11/2017
[68] Fieldnote, Wakefield, 28/11/2018

to consider how these decisions were made. Different staff had different indicators of when a move would be needed: signs and symptoms they expected to see that would assist in making the decision about when to move a prisoner, especially someone such as Eddie who had expressed a wish to stay on the wing. Identifying indicators for when the time was right to override his wishes seemed to be part of rationalising to themselves a decision they did not really want to make. Prison officers were frequently heard to ask nursing staff how long they thought Eddie would be on the wing.[69] One officer said he thought Eddie could stay until he couldn't think straight[70] another until it became "unethical", defined as the point at which respecting his wishes meant Eddie was receiving worse care.[71] For another officer, once Eddie needed to have 24-hour medical monitoring, he had to be in the healthcare centre because this wasn't possible on the wing. One of the nursing staff was clear a fall indicated Eddie needed to be moved to a cell with a bell near the bed,[72] something which had been rejected by officers a fortnight earlier when Eddie had said he didn't want the disruption.[73] Prisoners speculated about this too, with one suggesting Eddie would be moved if he became incontinent.[74] In essence, staff were trying to identify the 'crucial junctures' that would indicate Eddie had entered a new status in dying (Glaser and Strauss, 1968). It is striking that many of these were closely linked to the physical limitations of spaces within the prison, to when opening doors on the wing would be too disruptive to the established regime or when the physical environment of the cell would be inadequate to meet his needs.

HMP Leeds had also had experience of a terminally ill prisoner, Dean, being adamant he wanted to stay on the wing with his friends. In this case, they attributed his eventual decision to accept a move to H3 to his own growing awareness that he was extremely unwell and needed more help.[75] As his condition deteriorated, officers felt Dean needed to be in H3 for medical reasons[76] and nursing staff that he could have more input on H3; there were not enough nurses to care for him on the wing.[77] It is noticeable that in a lower security prison, Dean was granted more autonomy, but there were other differences between the lower security HMP Leeds

[69] Fieldnote, Wakefield, 30/1/2018
[70] Fieldnote, Wakefield, 30/1/2018
[71] Fieldnote, Wakefield, 23/11/2018
[72] Fieldnote, Wakefield, 13/12/2017
[73] Fieldnote, Wakefield, 30/11/2017
[74] Fieldnote, Wakefield, 7/2/2018
[75] Interview 1, Leeds
[76] Interview 3, Leeds
[77] Interview 1, Leeds

and the high security estate HMP Wakefield which did not reflect the prison's security status as might be expected.

One of the key indicators for when a move from the wings to healthcare would be required was an escalation in the type and amount of pain relief and care required. At HMP Wakefield, there was an assumption Eddie would eventually need pain relief administered through a syringe driver, and therefore for security reasons associated with the syringe, he would have to be in the healthcare centre. Although a lower security category prison, at HMP Leeds, a prisoner who had needed a syringe driver had been required to be sent to outside hospital because the prison authorities were not willing for healthcare staff to use syringe drivers anywhere within the prison, stating security considerations as the reason. Other medical reasons could be cited for the move from the wings to the healthcare centre. At HMP Leeds, the enhanced ratio of staff to prisoners was a factor,[78] as was the greater ability to prevent and control infections.[79]

Spatial location also indicated who was 'in charge' of the prisoner, specifically whether he was primarily a medical case or a discipline case. This was closely related to the perceived needs of a dying prisoner, and how much emphasis was placed on medical needs as opposed to social, psychological or spiritual needs. It also reflected the perceived risk posed by the prisoner. As one officer, at HMP Leeds said, in relation to how he saw staff attitudes concerning the location of prisoners as one of the barriers to good care: "they may think that 'someone is dying, they should go to hospital anyway, and we're here for fighting prisoners".[80]

For some of his colleagues, once a prisoner would not need "fighting", this was the stage at which nursing staff would take over.[81] Other reasons were given for why a move was beneficial. This included the impact on other people. With Eddie, there was a growing concern amongst prison officers about finding him dead[82] and an expectation that healthcare staff would see the signs and take over responsibility for him as this became more likely.[83] There was also a concern for the wellbeing of his carers, with his eventual move in part being attributed after his death to concerns about how caring was affecting them, as well as an awareness that because of the

[78] Interview 9, Leeds
[79] Interview 3, Leeds
[80] Interview 2, Leeds
[81] Interview 15, Wakefield
[82] Interview 13, Wakefield
[83] Fieldnote, Wakefield, 7/11/2017

wing regime, prisoner-carers could not provide as much care as he was needing.[84] His deteriorating health also meant keeping him on the wing was seen as unfair to other prisoners, because, as one custodial manager said: "your resources are having to be taken away from dealing with the normal day to day issues".[85]

The location of Eddie during his terminal illness and at the point of death serves to illustrate many of the characteristics of the spatial arrangement of the dying within prison, and the assumptions and expectations that inform the spatial ordering of dying prisoners within the physical environments available to them. The physical setting of the dying prisoner is also significant in how understandings of the dying prisoner are constructed, providing information used by others in attempts to make sense of what is happening. The location of the prisoner was used to construct understandings about his condition and the likely progression of his illness.

4.8 Expectations of location and understandings derived from location

The belief that prisoners who were unwell should be located in certain places was deep-rooted. Officers at HMP Wakefield accepted disabled prisoners might be on the wing, but "what they try and do here is if they are terminally ill, they move them to healthcare."[86] There was an assumption here that those at the very end of life would be placed in the palliative care suite. Healthcare staff felt aggrieved that when Eddie was finally taken over to the healthcare centre, the palliative care suite was unavailable, sealed off as part of the investigation following the death of another prisoner.[87] At the end of his life, they expected him to be located in the palliative care suite.

The spatial arrangement of a prisoner was also regarded as indicative of their state of health and stage of life, their place in the 'dying trajectory' (Glaser and Strauss, 1968). Other people read meaning into their location, surmising frailties and life expectancies from where they were located, assuming a deterioration or improvement if this location subsequently changed. Location became important in these speculations because the expectation of medical confidentiality meant reliable information was rarely openly shared beyond healthcare staff and the prison officers directly involved in the prisoner's care. For staff not directly involved in the decision, being moved to outside hospital or hospice might mean a terminally ill prisoner could

[84] Fieldnote, Wakefield, 17/5/2018
[85] Interview 6, Wakefield
[86] Interview 11, Wakefield
[87] Fieldnote, Wakefield, 7/2/2018

be expected to die soon; returning would be taken as a sign of improvement.[88] If they were willing to stay in the healthcare centre, it might be interpreted as meaning they were very ill.[89] The death of a prisoner in HMP Wakefield came as less of a surprise to a staff member who had worked with him because “everyone knew he was going to die. That’s why he was on healthcare”.[90] At HMP Wakefield, the palliative care suite was there for prisoners not expected to last long[91] and it could be assumed being located there meant death was imminent, although there were prisoners who had been accommodated there for other reasons when the suite was not needed by someone else. At HMP Leeds, where there was the possibility of sending a prisoner to a local hospice, this was often taken as evidence his death was expected, although in reality the prisoner may be moved back to the prison if his condition improved.[92] In this way, physical locations served to inform constructions of the dying prisoner, which will be further discussed in the following chapter.

Seriously and terminally ill prisoners were themselves assumed to make meaning from where they found themselves placed. At HMP Wakefield, there was a belief that people who went to the healthcare centre didn’t come back. It was referred to as the “green mile”,[93] and the palliative care suite was known to be referred to by prisoners as “the departure lounge” or “death’s waiting room”.[94] When asked, a nurse said Eddie was aware of this and she thought it was one of his reasons for resisting being located in healthcare.[95] The physical location thus conveyed a symbolic meaning. Eddie’s reluctance to be located in the healthcare centre meant his eventual transfer there was interpreted by other people as meaning he must have known death was imminent, either because he was prepared to be taken there, or because he interpreted his transfer as meaning other people thought he had very little time left.[96]

[88] Interview 16 & 9, Leeds; Fieldnote, Leeds, 4/7/2018; Fieldnote, Wakefield, 1/2/2018
[89] Interview 9, Leeds
[90] Interview 4, Wakefield
[91] Fieldnote, Wakefield, 1/2/2018
[92] Interviews 1, 8 & 16, Leeds
[93] Fieldnote, Wakefield, 7/11/2018
[94] Interview 4, Wakefield; Fieldnotes, Wakefield, 18/10/2017, 20/10/2017
[95] Fieldnote, Wakefield, 28/11/2017
[96] Interview 5, Wakefield

4.9 The rarity of release to die at home and the desire for a better setting

Having considered four locations associated with dying and death within prison custody, and the mobility of prisoners between them, it is important to consider a fifth 'space', that created by compassionate release. If a prisoner were to be granted compassionate release on the grounds of terminal illness, they would be removed from prison custody and the experience of dying transferred to a non-custodial location, without the rules or trappings of imprisonment. They would be free, and typically located in a family home, or a hospital or hospice, in a similar manner to other people at the end of life.

High profile cases where compassionate release was granted, such as those of the Lockerbie bomber, Abdelbaset Ali al-Megrahi, or the Great Train Robber, Ronnie Biggs, resonate in the public consciousness. In practice, compassionate release is very rare.[97] Although staff participants in the prisons studied recounted trying to achieve compassionate release for dying prisoners, both prisoners and staff could identify cases where they felt it was needed but hadn't been possible.[98] An officer with 27 years' experience, mostly at HMP Wakefield, could think of only one instance where compassionate release had been granted, for a prisoner who had suffered a stroke and died three weeks after being released to the care of the hospital.[99] Similarly, a member of a Senior Management Team with nearly 30 years' experience could think of only one prisoner who had been released to die, and that was described as being via the parole system, not a compassionate release.[100] As a result, in neither prison studied was there an expectation that prisoners would be granted compassionate release, even if it was desired. Unless the end of their sentence was imminent, a terminal diagnosis was expected to lead to a prisoner dying in prison custody, in a setting influenced by carceral geography, rather than at home. This is in keeping with studies of elderly prisoners elsewhere, which similarly report on the difficulties in obtaining compassionate release (Turner and Peacock, 2017). It was most marked in HMP Wakefield where there were significant numbers of people with indeterminate sentences and whole life tariffs. At HMP Leeds, where

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[97] Statistics on compassionate release are not routinely published by the Ministry of Justice but information from Hansard (HC debate, 10 February 2014) indicates that between 2009 and 2013, only 45 prisoners were granted compassionate release, including Abdelbaset Ali al-Megrahi, and Ronnie Biggs, during which time there were 606 deaths from natural causes in prison custody.
[98] Fieldnotes, Wakefield, 14/6/2018, 7/1//2018, 11/10/2017; Leeds, 1/12/2018. Interviews 9, Leeds; 14 & 6 Wakefield
[99] Interview 6, Wakefield
[100] Interview 13, Wakefield

the population included people on remand, there were examples of remand prisoners dying of natural causes. At this prison, participants spoke about a prisoner, Iain, who had received a terminal diagnosis between conviction and sentencing. His sentencing was delayed until he was well enough, a week before his eventual death. Healthcare staff in particular felt it was harsh that even in such circumstances compassionate release was not available.[101]

A number of difficulties were experienced with regard to obtaining compassionate release. Not all prisoners who might be considered for compassionate release could be 'sent home' and staff recounted difficulties in finding somewhere suitable to take prisoners. They felt hospices were reluctant to take a released prisoner because of the reputational risk of accepting a convicted sex offender.[102] This is consistent with the finding of Burles et al. (2016) that a prisoner's offences may make it difficult to access a hospice placement. Releases had also been prevented by disputes over which part of the NHS would take financial responsibility, especially for prisoners such as those at HMP Wakefield who had been away from their local area for a long time.[103] In one case, the process of getting compassionate release had been made more difficult by the prisoner's family's concerns about paying for the subsequent funeral.[104]

The most significant difficulties in obtaining compassionate release were attributed by staff to the expectations embodied in prison service rules and regulations regarding compassionate release. The Prison Rules (1999) specify the Secretary of State may temporarily release a prisoner on compassionate grounds or in order for them to receive medical treatment. They also state the medical officer of a prison should inform the Governing Governor of any prisoner whose health is likely be adversely affected by continued imprisonment and that the Governing Governor should report this to the Secretary of State immediately. However, it is clear from PSI 03/2016 that early release on compassionate grounds is only justified by exceptional circumstances. PSI 64/2011 takes a slightly different approach, saying that it is important to discuss early compassionate release with prisoners, but emphasising in two separate sections that prisoners may not wish to apply. If an

[101] Interview 10, Leeds
[102] Interview 7, Wakefield
[103] Interview 13, Wakefield
[104] Interview 13, Wakefield

application is to be made, PSO 3050 gives two grounds on which it may be considered:

> *a patient is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but 3 months may be considered an appropriate period*
>
> *or*
>
> *a patient is bedridden or severely incapacitated. This might include those confined to wheelchairs, paralysed or severe stroke victims.*[105]

Despite giving a time period of three months, PSO 3050 also says applications should be made as early as possible and can be reconsidered if the patient's condition deteriorates.[106] The input of healthcare staff as to how the prisoner's medical condition may affect their ability to reoffend is to be sought[107] together with a specialist opinion on life expectancy. Whilst the PSO recognises clinicians may not wish to provide an estimate of life expectancy, it persists in this requirement, saying: "personal contact between health care and the specialist to explain the process will often resolve this issue".[108] As Bolger (2005) highlights, this requirement of a prognosis that the prisoner will die within three months contradicts the principles of palliative care, which are opposed to setting such timescales.

In practice, staff in both HMP Leeds and HMP Wakefield had found the regulations on compassionate release unworkable. The difficulties were summed up by a senior member of staff at HMP Wakefield:

> *Usually the blockage on that is the information you'll get from the doctors on that because the two-liner saying "he's going to die in three months of this" really isn't enough to justify the compassionate release and we've fallen sort of foul of that. We've gone through the motions of the process but nobody has got released on compassionate release because we haven't got that medical evidence to support it, and that's really hard because a lot of that is out of our control* and *you're time bound with getting this so by the time you've got something in, if it takes 3 to 4 weeks, then you get to a point where somebody*

[105] PSO 3050 paragraph 7.18e
[106] PSO 3050 paragraph 7.18d
[107] PSO 3050 paragraph 7.18
[108] PSO 3050 paragraph 7.18e

is deteriorating too much to actually, it's less relevant because they are so near the end they that are probably going to die in prison anyway.[109]

In one instance, a senior prison officer working as an offender supervisor had tried in vain to use the parole system to get release for a prisoner with a terminal diagnosis. Time was against them.

> *He'd had a parole hearing but the parole board wanted to find a little bit more information out before, so we were trying to push the information through so we that could have another parole hearing. I think they give us 12 weeks, but we tried to push it through at about 6. I don't think he actually would have reached the 12 weeks period.*[110]

It was widely accepted that it was not good to die in prison[111] and the environment was part of the reason. At HMP Wakefield, two prisoners who knew they would die in prison spoke about desiring a better setting, agreeing that some sort of secure hospital would be better, somewhere that was still a prison but could more adequately meet the needs they expected to have at the end of life.[112] An elderly prisoner at HMP Leeds shared their view, describing his ideal as a secure hospital with lower security; as a wheelchair user he said he was not going to be able to escape. When asked why he preferred this to compassionate release, something neither of the men at HMP Wakefield had considered either, he said:

> *"Because justice has to be seen to be done". He says it's human nature to want to see that justice has been served; he doesn't expect compassionate.*[113]

His comment is reminiscent of Dawes (2009), writing from an Australian context, who suggested compassionate release "requires an act of 'forgiveness' by government on behalf of the community and may be difficult to achieve in the current climate" (p.268). Recognising the public has a desire for punishment to be delivered, prisoners saw that for the time being at least, compassionate release was not an option. As a result the physical locations in which terminally ill prisoners will typically be cared for and die becomes more significant to prisoners considering the prospect of dying in prison.

[109] Interview 7, Wakefield
[110] Interview 6, Wakefield
[111] Fieldnotes, Wakefield, 5/12/2017, 14/6/2018, 7/11/2017, 29/11/2017; Interview 8, Leeds
[112] Fieldnotes, Wakefield, 20/2/2018
[113] Fieldnote, Leeds,19/2/2018

4.10 Prison rules and the governance of mortality

In the four locations observed, one of the main influences on the experience of dying in prison custody was the large number of rules, regulations and guidance which control prison regimes and serve to translate power down the prison hierarchy. The sheer bulk of rules and regulations governing prison life leads Liebling and Maruna (2005) to observe with regard to prisoners that “it is difficult to know all the rules, much less comply with them” (p.105). Arguably the same could be said for prison staff. Difficulties in comprehending what is required in a given situation are not unusual within the prison service, as Loucks (2000, p.6) indicates:

> *Regulations governing the minutiae of prison life often represent an impenetrable bureaucracy. In order to uncover management policy, one has to unravel layers of rules upon rules.*

As would be expected, the majority of the nine documents reviewed, the Prison Service Instructions and Prison Service Orders, focus on the functioning of the prison, what is to be done, and how. There is considerable emphasis placed on where responsibility lies and on joint working between the prison and a range of organisations including other statutory bodies. In the context of dying prisoners, these include the Coroner, the Health and Safety Executive, the police, local hospitals and the Prison and Probation Ombudsman, reflecting a bureaucratisation of death in prison and an emphasis on accountability and investigation considered further in chapter six.

The documents reviewed share a number of common aims, including attempting to provide guidance and regulation on specific issues. A number of key principles are repeated with regard to seriously ill prisoners. This include the risk to the public and to prisoners being managed and minimised[114] (discussed further in chapter five), prisoners entitlement to the same standard of healthcare as the general public[115] (discussed further in chapter six), and establishing and maintaining partnerships with other bodies.[116] Boundaries are also defined within the PSIs, for example in PSI 17/2015 which defines the limits of intimate and personal care prisoners are permitted to provide to other prisoners. PSIs also designate powers and attribute responsibilities, such as to governors or to the prison officers fulfilling specific roles, and include lists of tasks for example with regard to the duties of prison officer in

[114] Graham v Secretary of State, 2007; PSI 03/2016, PSI 33/2005, PSI 64/2011
[115] PSI 33/2015
[116] PSI 03/2016, PSI 33/2015, PSI 64/2011, PSO 3050, PSO 0200

charge of a prisoner's escort or despatching escorts.[117] At times, the documents are overtly updating and changing existing practice, for example in PSI 33/2015, which explicitly states it is changing policy and ending single officer escorts.[118] These changes usually have the end goal of improving outcomes for prisoners and staff. For example PSO 3050 aims "to improve the continuity of healthcare received by prisoners"[119] and PSI 64/2011 aims, amongst other goals, to reduce deaths in custody and "ensure staff, prisoners and visitors affected by incidents of harm are supported appropriately".[120]

The prison 'rules' reflect a strong concern to record and demonstrate agreed practices. The focus of these documents is on risk assessments, the appropriate use of restraints, the practicalities of prison officers escorting terminally ill prisoners to hospital for treatment and ensuring that family members have been contacted by a nominated member of the prison's staff. None of these documents, however, is intended specifically to address the circumstances of a prisoner dying of natural causes. All of this is in stark contrasts to the usual concerns of good end of life care and shows the priorities which inform the responses of prison regimes and personnel to dying prisoners.

The documents reviewed go some way to explain how responses to dying prisoners are determined, showing the limitations and possibilities that exist if prison regimes and personnel seek to follow the requirements and guidance set out in these documents. They illustrate the "rational schema" of prisons (Foucault, 1991b, p.80) but also form part of the prevalent discourse about dying in prison. The 'rules' illustrate a number of assumptions with regard to prisoners and deaths in custody that are apparent through where attention is directed. For example, there are assumptions revealed about the likely causes of deaths in custody. PSI 64/2011 focuses on deaths from suicide and violence more than those from natural causes, despite the dominance of natural causes in the statistics for deaths in prison custody. In doing so, it is implied that prison authorities erroneously see deaths as typically unnatural, unexpected and preventable. This is more marked in the PSO 0200, where the assumption is that deaths will be unexpected, occur in the cell and that first aid interventions will be appropriate. These assumptions are not borne out by the published statistics on deaths in custody, nor by the experiences of many of the prison staff involved in this study. What becomes clear is that the rules,

[117] PSI 33/2015
[118] PSI 33/2015, 1.4
[119] PSO 3050, p.1
[120] PSI 64/2011, p.4

regulations and guidance directing the achievement of prison and shaping discourses about prisoners have not been updated to reflect the impacts of an increasing number of prisoners dying from natural causes.

4.11 Conclusion

With compassionate release being so rare, the physical environment of the prison became more important to the experience of dying. It is this aspect of carceral geography, together with the rules associated with imprisonment, which sets dying in prison apart from dying in other places.

Dying in prison custody typically occurred in four possible locations: the prison wing, the healthcare centre, a palliative care suite (if there is one) or outside hospitals or hospices. Prisoners had very little control over their mobility between these spaces. Where a dying prisoner was located was decided by the direction set by the Governing Governor, but other staff, particularly healthcare professionals, also had a role in determining where a prisoner was placed. Staff and prisoners looked for indicators, usually of deterioration, that meant a prisoner needed to move to a new setting. Meanings were read into the physical location of a dying prisoner, with their spatial arrangement being seen to signify their place in a dying trajectory.

The desire to meet the changing needs of dying prisoners impacted on the physical setting of the prison, mostly notably in the commitment of some staff, especially healthcare professionals, to re-purpose spaces as suitable for palliative care. This was also apparent in small adaptions to the physical environment such as leaving doors unlocked or introducing soft furnishings into a palliative care suite. These served symbolic as well as practical purposes. In the prisons studied, there were changes to the regime resulting from the experience of caring for dying prisoners. A terminal diagnosis was usually seen as indicating a prisoner should move to the healthcare centre or H3, but there were exceptions, as Eddie and Dean’s cases show. Physical adaptions were made on wings to meet the needs of frailer prisoner, including lowered doorsteps, more convenient cell bells and additional bedding. Significantly, as Eddie’s case illustrates, it was only possible for a dying prisoner to remain on the wing if they had supportive friends to care for them. Such choices would not be open to all prisoners, and were not extended permanently.

Each of the spaces associated by staff and prisoners with dying had its own characteristics. It is apparent that whilst there is not a single direction of movement through these spaces, there is a continuum of the blurring of ‘inside’ and ‘outside’

which reflects assumptions that prisoners closer to the end of life will be located in the prison's healthcare centre, and as death approaches, in a palliative care suite. Away from the starkness and physical limitations of the prison wing, the border between 'inside' and 'outside' softens slightly in the more relaxed regimes such as H3 in HMP Leeds. In the palliative care suite, this softening is more marked, embodied in soft furnishings and artworks that demonstrate the attempts of some professionals to recast the individual as primarily a 'patient'. There is a deliberate introduction of features which represent the 'outside', with the intention of lessening the physical signs of imprisonment and creating an environment which healthcare professionals associate as being appropriate for dying. Despite these efforts, these are still deaths in prison custody and the physical markers of such remain evident.

In the hospital, the boundary between 'inside' and 'outside' becomes entangled. The accompaniment of the prisoner by prison officers brings into the hospital the trappings of incarceration: prison uniforms, prison equipment and often the physical restraints of handcuffs or an escort chain. In this respect, the requirements of a prisoner's ongoing imprisonment impinge on the physical environment of the hospital bedside and whilst the prisoner is materially outside the prison they are simultaneously representationally inside. The physical environments in which prisoners die are therefore very closely associated with the experience of imprisonment, and very different surroundings from the places where most people expect to die.

What is possible with regard to the care of people dying in prison is largely determined by the rules and regulations governing all aspects of behaviour of both staff and prisoners. Prison 'rules' can serve as a barrier to obtaining compassionate release, where the specified criteria no longer match good practice in palliative care in the community, or as a descriptor of practice, such as cuffing arrangements for hospital escorts. They are also part of forming discourses about dying prisoners and, together with the symbolic meanings present in understandings of carceral geography, contribute to constructions of dying prisoners and of quality care, as discussed in the next two chapters.

Chapter 5: Constructing the dying prisoner

5.1 Introduction

This chapter examines how the identity of being a dying prisoner is constructed. When a death is anticipated, the construction of the individual relies on understandings of dying which are themselves culturally influenced, as Seale (1998, p.1) argues:

> *our own constructions of death, dying and bereavement… are in fact specific to the conditions of late modernity and, indeed, are dominated by the conceptions of particular social groups.*

The construction by staff of an individual dying prisoner is influenced both by a perception they are dying and by the implications of their situation as a prisoner. For the prisoner, many aspects of their lives in prison are shaped by the attitudes of staff. The attitudes of prison officers are particularly salient, since as Hay and Sparks (1991) argue, "uniformed staff are the people who have the most contact with prisoners, often in the most difficult circumstances" (p.415). Staff understandings of the figure of the dying prisoner could arguably be closely related to a more general construction of the prisoner. This chapter will explore how staff, particularly those working with dying prisoners, and other prisoners, construct the figure of the dying prisoner and how this differs from understandings of other prisoners. It will pay particular attention to how prison officers construct dying prisoners and what underlies these constructions. It will also highlight where there is divergence in the figuring of the dying prisoner by staff in differing occupational roles. It is suggested here that how individuals who are dying are constructed by the staff working around them can potentially determine the responses of prison regimes and personnel to their situation.

The chapter is arranged in five parts. It will begin by exploring how dying is defined by prison staff and prisoners, including examining how prisoners self-define as expecting to die in prison and the close link made by participants between ageing and dying. This section will also consider how the increase in such deaths in recent years has changed the place of death within prison culture, such that dying prisoners are perhaps less marginalised by their terminal diagnosis than may be expected.

Secondly, the chapter will consider how different groups of people within the prison apply differing dominant statuses to the figure of the dying prisoner. In particular,

attention will be paid to the clear tension between the figuring of the individual by healthcare staff as a 'patient' and by prison officers as a 'prisoner', terms which evoke different levels of humanity. These constructions will be seen to sit alongside the rarer construction of the individual as a 'person'. Examples will be provided of how the different dominant statuses given to dying individuals affect the interactions staff have with them and therefore influence the care received at the end of life. The importance of occupational culture will be considered here, alongside the extent to which matching the expectations of occupational culture is achievable when prisoners are especially stigmatised.

The third section of this chapter considers three implications of constructing the dying individual's dominant status as 'prisoner'. It examines how by figuring the individual as a 'prisoner' they become someone who is stigmatised, who is seen as posing a risk to others, and who is denied autonomy. How this influences the experience of the dying prisoner is explored particularly with reference to the experience of hospital escorts, the use of restraints and the limited scope for agency available to prisoners receiving palliative care.

The next section of this chapter will consider the effects of seeing the prisoner as a 'patient' or 'person', and the extent to which this is an achieved priority within the two prisons studied. The effects of imprisonment are in some circumstances lessened by the new constructions of the individual resulting from a terminal diagnosis, allowing prisoners to be afforded more humanity by staff, including prison officers. The mechanisms for this will be explored, including the importance of constructing the prisoner as part of a family. The circumstances and limitations of sympathy in restoring a prisoner's humanity in the eyes of staff will also be considered.

Finally, the chapter will consider how the dead prisoner is constructed, exploring how aspects of the construction of the individual persist or change after their death. Attention will be turned to what influences understandings of the prisoner's worth after death, and how this is reflected in whether they are regarded as 'grievable' or deserving of memorialisation. The increasingly frequent task of memorialising the dead is a new role for prison staff, observed closely by prisoners aware they may one day die in prison. The need for memorialisation arises out of a construction of a prisoner as someone who is deserving of respect after death, regardless of being incarcerated at the end of life. The dead prisoner will be seen to also take on new identities, as a potential victim of crime and as a possibly estranged family member, that influence how they are treated even after death.

5.2 Defining expectations of death and dying in prison custody

As Glaser and Strauss (1968) state: “Dying must be defined in order to be reacted to as dying” (p.242). Both staff and prisoners demonstrated ways in which they constructed a personal understanding that a prisoner was dying. In part, as discussed above, this was influenced by physical location. Often it was based on the prisoner’s physical condition, with weight loss, pale or yellowing skin colour and an increased dependence on pain relief regarded as indicative of the approaching end of life.[121] Sometimes, participants knew of other people, including their own family members, who had died of the same condition and when they were aware of a prisoner’s diagnosis, assumed they were therefore dying.[122] More generally, death was regarded as something that happened to the elderly and associated with an ageing prison population. For example, one staff member said:

> *I think especially with the population of Wakefield, it’s an ageing population and with older people you tend to get a lot more terminal illnesses or people who they are going to die aren’t they?*[123]

Staff at HMP Wakefield in particular encouraged me to watch the regular movement of prisoners across the ‘centre’ at the beginning and end of every session. They wanted me to see for myself the age and physical infirmities of the prison population, equating this to a demonstration of the extent of the tasks they would face in the future in responding to prisoners dying in prison custody. Similarly, at HMP Leeds senior officers assumed I would spend much of my time on F wing, where the population was noticeably more elderly, based on the perceived link between ageing and dying. For some very old prisoners, it seemed to be accepted that because of their age there was no other option than death in prison custody. One prisoner in HMP Leeds spoke of helping a peer put his affairs in order. He:

> *tells me about a new arrival on H3, aged 92. He says he’s been helping him sell his house and change his will. The assumption that the man will die in prison is unspoken.*[124]

A number of prisoners at HMP Wakefield with long sentences anticipated dying in prison and spoke to staff about this. One governor at HMP Wakefield recounted talking to a prisoner who regularly said he would die in prison and spoke about a

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[121] Interviews 4 & 15, Wakefield; Fieldnotes, Wakefield, 1/2/2018, 28/11/2017, 28/11/2017
[122] Fieldnotes, Wakefield, 7/11/2017, 9/2/2018
[123] Interview 4, Wakefield
[124] Fieldnote, Leeds, 25/6/2018

conversation with another, not terminally ill, but already planning his funeral "because he doesn't think he'll finish serving his time out".[125]

Deaths from natural causes were regarded as inevitable and as having always happened in prison custody. One participant, when asked if he had expected when he became a prison officer to be working with prisoners who were dying, summarised this by saying: "you come into it knowing that you are in a city that's behind a wall basically. That's what it is… and everything that happens outside happens inside."[126] Staff coming in through the front entrance to the main building at HMP Wakefield had a daily reminder that death from natural causes was part of the history of the prison. The wooden board listing the prison governors since 1611 included: "1825 Thomas Shepherd (died of cholera in prison with 29 prisoners)".[127]

What had changed in recent years was that deaths from natural causes had become a more common occurrence. Participants made a strong link between this and the ageing population of the prisons where they lived or worked. The prisons selected for fieldwork were chosen, as discussed in chapter three, because they had experienced a relatively high number of deaths from natural causes in the five years prior to the research. The frequency of these deaths was discussed by participants, especially in HMP Wakefield, which had had the second highest number of such deaths in the country. At HMP Leeds, comparisons were made with HMP Wakefield where it was recognised that deaths from natural causes were more common occurrences. For a staff participant at HMP Leeds, he could see the trend in high security prisons such as HMP Wakefield expanding out to the local prisons such as HMP Leeds:

> *And it's because there's not the spaces in the Cat A, Cat B estate, they're with us a lot longer than normal. I mean a lot will come to us on lengthy sentences and won't get to the next jail. … It's summat that over the coming time will need addressing, but it's going to be a national problem. It's not just a local problem, it's a national problem.*[128]

What was significant at HMP Wakefield was the way in which the frequency of deaths from natural causes was shaping prison culture, as apparent in the example above of how readily prisoners imagined their future deaths in prison custody in

[125] Interview 13, Wakefield
[126] Interview 6, Wakefield
[127] Fieldnote, Wakefield, 6/4/2018
[128] Interview 9, Leeds

conversations with prison staff. Staff in this prison were aware when a death occurred:

> *everybody is thinking "one day is that going to be me?"… For most of our prisoners, one day, it will be them dying in custody.*[129]

When there had been a number of deaths on one wing, it was recognised that this reflection could become more pointed. In 2016, 11 prisoners died of natural causes at HMP Wakefield, the majority of whom had been resident on the same wing:

> *I think out of the 11 we probably had six off D wing, had all originated D wing. And y'know, I think prisoners begin to think "Hmm, probably not the right place to be if I'm not feeling too well", y'know "Is it me next".*[130]

There was no indication of why this had happened, but several prisoners commented on the coincidence of so many deaths in one year being on D wing, referring to it as the 'death wing'.

At the start of the research, it was expected most people would find the subject matter potentially painful, and that the sensitivity of the subject would lead to some reluctance to participate. Instead, in HMP Wakefield in particular, there was a very noticeable willingness to talk about the subject, with new participants often approaching the researcher to share their experiences. Staff in this prison also found the subject of dying arose at unexpected times, sometimes in casual conversation and, without any great significance being placed on it, but also more poignantly and personally. One talked about reprimanding a terminally ill prisoner for using inappropriate language in a group situation, only for him to retort:

> *"What are you going to do L (first name)? What are you going to do? I'm going to die." And I'm like that "Oh, for God's sake, stop it." And then he'd just laugh and "Oh, I'm only kidding". And everyone would laugh about it.*[131]

Another staff member reported a conversation with one of the younger prisoners about the plans to decorate the palliative care suite:

> *His immediate response was dismissive "I'm not interested in that", but as we talked more about the technique that was used for the artwork he seemed to have something of a lightbulb moment. He paused and said "I should be more*

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[129] Interview 7, Wakefield
[130] Interview 13, Wakefield
[131] Interview 4, Wakefield

> *interested in that, because I'm going to die in prison. It's not something you should really be aware of at 25 is it? But I think I should consider that more."*[132]

In her account, both she and the prisoner were taken aback by the certainty a 25 year old could have that he would die in prison. A topic neither expected to be relevant to someone of his age became significant because the length of his sentence meant the setting of his death, however many years in the future, was now known.

The frequency with which deaths from natural causes happened in HMP Wakefield, and the number of people known to have sentences which would likely mean they would die in prison, had seemingly reduced any supposed sensitivity about the subject. It may also have increased the need in staff and prisoners to talk with someone, the researcher, who seemed interested. This is in contrast with the typical approach of research ethics committees, where death and dying are regarded as topics participants are likely to find distressing. This willingness to talk about death and dying suggested that death had become a recognised part of the experience of imprisonment, an acceptable topic of conversation, even with a stranger. The place of death in the culture of this prison was thus different from what might be expected. Dying in this prison was regarded as a relatively normal occurrence, and discussing it was far from taboo. (See Ariès, (1976) and Walter (2015, 1999) on death as a taboo and death denial in modern culture.)

Burles et al. (2016) argue dying prisoners are doubly marginalised, by the fact of their imprisonment and the circumstance of dying. As discussed in chapter four, dying prisoners could find themselves physically marginalised, separated from their peers in Wakefield's healthcare centre. The resistance to this is demonstrated in Eddie's determination to remain on the prison wing after receiving his terminal diagnosis, even when quite frail. Arguably, however, the ease with which dying and death was discussed within HMP Wakefield reduced the marginalisation of death, suggesting that the condition of dying prisoners was not culturally marginalised, but something that could be discussed and was part of the expected experience of imprisonment for many long-term prisoners.

The situation was different at HMP Leeds. There were prisoners at HMP Leeds who expected to die in prison, but there were fewer of them and death did not seem to be a topic of conversation amongst prisoners outside those immediately affected by it.

[132] Correspondence, Wakefield, 27/4/2018

A handful of prisoners at HMP Leeds, all of them elderly, expressed an awareness they would die in prison. Some of them anticipated this as being at HMP Leeds, perhaps aware, as the officer quoted above, that the lack of spaces in other prisons meant they could not be moved on. One shared a letter from his cardiologist, written prior to sentencing, which specified he had a 70% chance of living five years, odds he clearly found unfavourable. He had hoped his cardiologist's letter would influence the court, but was given a 16-year sentence. He said he had accepted he would die in prison, but he felt apprehensive about this.[133] Another prisoner in HMP Leeds envisaged the exact location of his death, and in conversation said: "he hopes to just die in his sleep, pointing at his lower bunk as he says this".[134] Prisoners also spoke to each other about expecting to die in prison, with another prisoner in HMP Leeds saying, "one of the men downstairs says he's only leaving in a box",[135] but they conversed about death less readily than at HMP Wakefield.

In both prisons studied, there was generalised acceptance that deaths from natural causes in prison custody were to be expected. There was also an individual expectation of death, seen mostly in elderly prisoners but also in prisoners with long sentences, particularly at HMP Wakefield. Age, particular medical conditions, physical location and physical appearance were all associated by participants as indicating a prisoner was nearer death. In HMP Wakefield, the frequency with which such death occurred meant dying from natural causes was no longer seen as unusual. It was an occurrence which had impacted on the culture of the prison, on what it was acceptable to talk about, and what was seen as part of the experience of imprisonment.

5.3 Dominant status: 'prisoner', 'patient' or 'person'?

Studies of prison staff working with dying or frail prisoners commonly find they do not differentiate in their treatment of them from other prisoners (Crawley, 2005b; HMCIP, 2004). Crawley (2005b) finds that this "flattening of different needs" (p.357) means elderly prisoners are required to fit in with existing routines and practices and struggle as a result. Similarly, Aday and Wahidin (2016), writing about the difficulties of reconciling the values of prison hospices with the security concerns of a prison, find:

[133] Fieldnote, Leeds, 19/2/2018
[134] Fieldnote, Leeds, 1/5/2018
[135] Fieldnote, Leeds, 25/6/2018

> *Prisons, as a rule, have promoted conformity rather than individuality and frequently dehumanised criminals who are perceived to have little worth. (p.320)*

Although prison officers have the most contact with prisoners (Hay and Sparks, 1991), other prison staff with different occupational cultures also have close involvement with terminally ill prisoners. This is especially the case, as discussed in chapter four, when a prisoner is transferred to the prison's healthcare centre, and deemed, in the eyes of some staff, to have become a 'medical' rather than a 'discipline' case. Even amongst prison officers, there are different ways of categorising prisoners and even then, in their study of another high security prison, HMP Whitemoor, Liebling, Price and Shefer (2011) found some officers resisted their colleagues' efforts to categorise prisoners, preferring to see prisoners just as human beings. Sykes (1958) suggests "in the eyes of the custodian, the inmate tends to become a man in prison, rather than a criminal in prison"' (p.55) but the situation in the prisons studied was more complicated.

In both HMP Wakefield and HMP Leeds there was a tension over whether the dominant status of someone dying in prison was regarded by staff as being that of a 'prisoner', 'patient' or 'person'. Prison chaplains used 'person' more readily than the term 'prisoner'[136] but the use of language did not seem to be a contested issue for them. Instead, the division was typically characterised as officers seeing the individual primarily as a 'prisoner', and healthcare staff thinking of them primarily as their 'patient'. Prisoners were aware of this dichotomy, as were officers[137] but it was healthcare staff who raised it most frequently and felt most passionately about the use of language. Officers routinely described the individuals they worked with as 'prisoners', or 'them', this latter term also being used by prisoners to refer to officers. It was noticeable that 'prisoner' was consistently used by officers in preference to 'inmate' or 'resident'.[138] The terms 'offender' or 'criminal', which would have foregrounded the offence, were not used, with the exception of a poster in the healthcare centre at HMP Wakefield. Instead, 'prisoner' described someone incarcerated and placed in the care of prison personnel. In keeping with Liebling et al. (2011), some staff, including officers, emphasised prisoners should be seen as

[136] Three prison chaplains were interviewed. The individuals they cared for were referred to by the term 'person' 39 times, as a 'prisoner' 21 times (four times echoing a phrase from the interviewer) and only once as a 'patient'.
[137] Fieldnote, Wakefield, 30/11/2017
[138] As discussed in chapter one, during the fieldwork in HMP Wakefield, prisoners were consulted on which term they preferred and chose 'prisoner'.

human beings.[139] Seeing someone as a ‘normal person’ or ‘human’ was regarded by many of the prisoners who participated in the study as the gold standard. They expressed appreciation for when this had happened[140] and regarded it as indicative of a lack of care when it did not.[141] Nursing staff also regarded this as the ideal, perhaps reflecting a different occupational culture from prison officers (Thomson and Parrish, 2002), but maintained a preference for the term ‘patient’ rather than ‘person’ for someone who was unwell.[142]

An account given by a healthcare professional at HMP Leeds of trying to co-opt officers on a wing to assist with the care of Dean is illustrative of the attitudes associated by healthcare staff with the different occupation roles of officers and nursing staff. The nurse recounted saying:

> *“I need you to be supportive of this because he’s staying on the wing and I need everyone involved.” And one of them went “Oh, I’ll help you. I’ll carry his coffin” And I went, I said “Do you know what, that’s why you’re a prison officer and I’m healthcare, because of that disgusting attitude”. And I went and reported it.*[143]

Officers were aware of the reputation they could have in this regard. Prisoners regarded officers as typically seeing them as ‘a number’, a statistic, with a death equating to just ‘one off the roll’.[144] They also contested the extent to which healthcare professionals did view them as ‘patients’, both in the prison’s healthcare centre and when receiving treatment in outside hospitals, believing instead they were seen by healthcare staff primarily as ‘prisoners’.[145]

Whilst healthcare staff in both prisons spoke about having to defend their construction of the individual as a ‘patient’ against officers who insisted they were ‘prisoners’,[146] it was noticeable officers almost never mentioned these disagreements. In the one case where the differing constructions of seriously or terminally ill individuals was raised by an officer, the balance of statuses between ‘patient’ and ‘prisoner’ were attributed to his location. He described individuals

[139] Interviews 13, Wakefield; 12 & 9 Leeds; Fieldnote, Wakefield, 7/2/2018, 14/6/2018, 12/6/2018
[140] Fieldnote, Leeds, 19/2/2018
[141] Fieldnote, Wakefield, 14/6/2018
[142] Three nurses were interviewed. The individuals they cared for were referred to by the term ‘patient’ 33 times, as a ‘person’ 9 times and only 2 times as a ‘prisoner’.
[143] Interview 10, Leeds
[144] Fieldnotes, Wakefield, 14/6/2018, 7/2/2018
[145] Fieldnote, Wakefield, 30/1/2018
[146] Interviews 1 & 10, Leeds; Fieldnote, Wakefield, 23/10/2017

accommodated in the healthcare centre as “patients before they are prisoners”, whereas the focus of their treatment on the wing was about discipline.[147]

In defending their figuring of the individual as a ‘patient’, little distinction was made by healthcare staff with regard to the severity of any medical diagnosis. Instead there was an emphasis on the relationship between the individual and the healthcare staff: “they’re my patients” or “our patients”.[148] The construction of the individual as a ‘patient’ was heavily influenced by the position of the person doing the figuring, with one nurse saying: “It doesn’t matter what they’ve done, they are my patient because I’m a nurse”.[149]

Which status was regarded as dominant did have some effect on the care received by a dying prisoner. Nursing staff spoke about trying to undo behaviours associated with being figured as ‘prisoner’. They reported needing to persuade people who had been moved to the healthcare centre that they would be treated differently, including encouraging them to press their cell bell when needed, in contrast to the approach taken by officers on the wing.[150] One nurse spoke about a nursing colleague having held the hand of a dying prisoner, and officers disapproving, although for the nursing staff this was a normal part of nursing.[151] Savage (1999) says modern nursing care expects at least a theoretical involvement with the patient, and that medical outcomes will be achieved through emotionally close relations. In the prison context, other studies (Burles et al., 2016; Thomson and Parrish, 2002) suggest nursing staff have to be careful that compassionate behaviour such as this is not misunderstood by prison officers: “healthcare providers face the ongoing challenge of providing care and comfort to ailing patients amidst an atmosphere of animosity towards the individuals for whom they care” (Burles et al., 2016, p.101). At HMP Wakefield, nurses were cautious in this regard, consciously adapting their nursing techniques to the prison and aware they would still face disapproval:

> *because when you’re nursing people on the ward you’re very touchy feely and you’re cuddling and touchy, whereas here you’ve just to be that little bit more careful, but sometimes you can be a good judge and think yeah I can hold his hand, or ‘hmm’. Then again, officers: “what are you doing that for?”.*[152]

[147] Fieldnote, Wakefield, 30/11/2018
[148] Interview 1, Leeds
[149] Interview 10, Leeds, 2/5/2018
[150] Interview 12, Wakefield
[151] Fieldnote, Wakefield, 7/11/2017
[152] Interview 12, Wakefield

This is in keeping with Aday and Wahidin (2016) who suggest in prison “even simple, platonic gestures such as touching a patient’s hand or shoulder during an assessment, are often discouraged” (p.320). In HMP Leeds, touch was observed being used by nurses more naturally,[153] but the construction of the individual by officers as primarily a ‘prisoner’ was still regarded by nurses as adversely affecting their social care. Laughter was seen by healthcare staff as important to mental wellbeing, but one senior nurse felt some officers saw it as inappropriate, and akin to ‘conditioning’, the term used to suggest prisoners are ‘grooming’ or training staff so they can be corrupted or manipulated.[154]

5.4 Seeing the ‘prisoner’

The implication of constructing the individual as a ‘prisoner’ is that it evokes someone who is potentially dangerous, who poses a risk because of their past and potential future behaviour. The ‘prisoner’ is someone inherently stigmatized. Constructing the individual dying in prison as primarily a ‘prisoner’ brings with it a diminished assessment of their value because of the stigma associated with the status, prioritises security considerations and maintains the deprivation of autonomy associated with imprisonment. Understandings of people dying in prison as primarily ‘prisoners’ will be seen to direct the ways in which prison regimes and personnel respond to the dying.

Stigmatized individuals

Goffman (1963) defines stigma as an attribute or characteristic that is discreditable to the self. He illustrates this by identifying prisoners as a stigmatised group. Whilst in prison, efforts are made by prison staff to keep track of and control prisoners’ behaviour in a manner that never neglects their inherently stigmatised status. This continues even, as will be seen, in the circumstances of approaching death, although broader cultural attitudes towards death and dying helped some staff, in their minds at least, to partially restore the fuller humanity of dying prisoners.

Outside of the prison, escorted to hospital or hospice appointments, prisoners became more conscious of their stigma because it was physically manifested in the escort chain they might have to wear. The rules, regulations and guidance of the Prison Service include provisions for the use of restraints in such cases, discussed

[153] Fieldnote, Leeds, 27/4/2018
[154] Fieldnote, Leeds, 27/4/2018

below with regard to other security considerations. Prisoners who had attended appointments or received treatment in outside hospital had two common responses to the use of restraints; they were unnecessary and they provoked an unwelcome response from members of the public. Once seen to be in restraints, the individual was clearly identifiable to as a prisoner. Four prisoners in particular, on separate occasions, explained how this affected them. One prisoner said people stood aside, fearful of him.[155] Another reported the same response, but demonstrated bravado in saying he enjoyed having people wonder what he had done.[156] A third prisoner, a wheelchair user, said attending hospital appointments was 'traumatic' because of the chain:

> *He says people are looking at you, indicating what he means by turning his head round to the sides and staring. He says they are wondering what he's done, what awful thing. He goes in his wheelchair, with staff pushing him. Even though the hospital knows he's coming, he has to sit in the waiting room, sensing people are looking at him, for maybe up to an hour and a half.*[157]

Another wheelchair user was simply grateful he was only on an escort chain and not additionally double cuffed, wrists cuffed together.[158] What is striking here is the way in which prisoners experienced being a public spectacle whilst restraints were used. The Prison Rules (1999) provide the principle that an individual being escorted outside of the prison:

> *shall be exposed as little as possible to public observation, and proper care shall be taken to protect him from curiosity and insult.*[159]

It is significant that in a relatively brief document, this is accorded so much importance. The rules are seeking to protect the prisoner from becoming a public spectacle. The escort chain, whilst keeping the prisoner from the public, undermines this and serves as a stigma, marking the individual as a prisoner and thus attracting public attention. It is one of the examples of stigma given by Goffman (1963). Staff were aware of this stigma, with one member of the prison's nursing staff saying of her hospital colleagues: "it's understandable, if the nursing staff see someone in cuffs, that they think the worst"[160] and relating this to her own experience of working

[155] Fieldnote, Wakefield, 30/1/2018
[156] Fieldnote, Wakefield, 11/10/2017
[157] Fieldnote, Leeds, 19/2/2018
[158] Fieldnote, Wakefield, 19/7/2018
[159] The Prison Rules 1999, SI 1999/728, 40.1
[160] Fieldnote, Leeds, 4/7/2018

in a hospital, knowing if someone was brought in under escort and restrained they had “done something serious”.[161] Officers had to respond to public concerns arising from the stigma embodied by the restraints. An officer observed on a ‘bedwatch’ reported a nurse in the hospital had asked whether the man posed any risk to children visiting other people on the ward.[162] The use of restraints thus directly led to the construction of the dying prisoner by those outside of the prison as someone who posed a risk or was potentially responsible for abhorrent crimes.

Within the prison, some prisoners could be singled out for additional stigma. In HMP Wakefield this included indicating if a prisoner was category A by the use of red card for ID badges and cell labels. Others would have to be unmasked, in this case to the researcher, as ‘no-one-to-one’, meaning they were judged to pose a heightened risk if with someone by themselves. Some offences, particularly against children or of a sexual nature, carried an additional stigma. In HMP Leeds, where vulnerable prisoners were accommodated separately, those convicted of sexual offences were more readily identifiable by staff and other prisoners because of their location. This was less possible in HMP Wakefield, where there was no such separation. However, any attempts by prisoners to conceal additionally discreditable convictions was unlikely to succeed with prison staff who have access to the prisoner’s record.

Spencer and Ricciardelli (2016) argue in their study of correctional officers’ attitudes towards sex offenders that: “While officers are primarily attuned to their occupational culture, they are also embedded in broader society and affected by their interactions with prisoners” (p.382). This was the case in the prisons studied. Whilst some officers and staff in other roles tried not to think about a prisoner’s offences, others were very aware of their crimes, and when these were of a sexual nature, this awareness could impact on how they felt about working with them. In some circumstances the additional stigma of conviction for certain offences made sympathy less likely to be extended to some dying prisoners, even when officers felt, as discussed below, their occupational culture expected them to feel sympathetic.

An officer spoke about working with a prisoner who was dying during the fieldwork period as:

[161] Fieldnote, Leeds, 4/7/2018
[162] Fieldnote, Wakefield, 19/7/2018

harder than some of the others I've done, mainly because he'd just got a 36 year sentence, er, for sex offences against children. … Er, so trying to keep professional but having that at the back of your mind's been really difficult.[163]

Another officer spoke frankly about her feelings towards prisoners who had harmed children, saying:

> *Because a lot of people see it as erm, "they've done a crime, they're here, that's it, that's the end of it". As I see it as more of "they've caused suffering to someone else, so if God's given them this path to go down, then that's just the way it is". Sometimes it's an eye for an eye. So I kind of [two second pause] see it as justice in my eyes… You're working with these, and we're all about rehabilitation and once they come in here "they've done the crime, however, they're still a normal person and de de de de". But unfortunately, someone's killed a child or raped a child, when they are dying, I'm not really feeling <u>any</u> kind of empathy for them…I find it hard, if I'm being honest, to feel sorry for someone when they've caused probably a lot worse to someone else.*[164]

The revulsion she felt towards prisoners who had harmed children was clear; she did not mind they were dying in prison. In both these cases, the officers interviewed felt the expected professional standards required them to not think differently about a prisoner because of the nature of his offences, but they found this difficult to achieve. By emphasising what she felt "if I'm being honest",[165] there is a suggestion such honesty was not always possible. Both of these officers were female and it may have been they were navigating professional norms that intersected with gender norms, struggling not appear "too soft" in an evolving occupational culture traditionally regarded as macho (Tait, 2011; Cheek and Miller, 1983).

Emotional labour is recognised as crucial to the functioning of a prison (Crawley, 2004). Tait (2008b) maintains there is a gender difference in what emotional displays are acceptable amongst prison officers, with male officers facing occupational cultural pressure to be 'hard' which female prison officers do not experience to the same extent. The situation suggested by the two female officers quoted here is clearly more complex. Spender and Ricciardelli (2016) find in a Canadian context that "correctional officers' feelings of disgust towards sex offenders render them less-than-human" (p.390), but in this research project it was

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[163] Interview 16, Leeds
[164] Interview 15, Wakefield
[165] Interview 15, Wakefield

only female officers who expressed such feelings, directed towards prisoners guilty of specific offences, particularly those against children. Working with these men if they were terminally ill meant that for much of the time, they were engaged in emotional labour, performing the necessary 'surface acting' to hide deeper feelings they deemed unacceptable in their working environment. Their male colleagues may have felt the same, but spoke more generically about the nature of the crimes committed and implied less of a conflict in performing the 'deep acting' required to set aside the specifics of the offences for which the prisoner was convicted.

> *Regardless what these people here have done, and some of these, the majority of what's in this prison are the worst offences in the country, horrendous, but you're still responsible for the care of what they are about.*[166]

The tension inherent in providing this care whilst regarding the prisoner's offences as "horrendous" required forms of emotional labour and deep acting. One approach to this was described by an officer who regarded some prisoners as "horrid"[167] and found knowing the details of their crimes could provoke anger. He suggested he could set aside these feelings if the prisoner was regarded by trusted colleagues as helpful to staff and not a difficult prisoner. For such officers, the prisoner was less stigmatised by his crime, more judged on his behaviour towards prison staff. The dilemma of showing care for someone stigmatised by the horrific things he had done was therefore lessened.

Security considerations and prison 'rules'

Male prisoners are classified as category A, B, C or D according to how likely they are to try to escape and their risk of causing harm to other prisoners and prison staff. The two prisons in the study housed category A prisoners, (HMP Wakefield) and category B prisoners (HMPs Wakefield and Leeds). As such, security matters dominated all other considerations. The need to impose order and maintain security was embodied in the rules, regulations and guidance which govern the management of all prisoners, and which continued to be relevant in the treatment of dying prisoners. However, as Lillie (2018) states, "the propensity to focus on security can lead to an unnecessary diminishment of dignity in dying" (p.49).

Whilst rarely explicitly addressing the circumstances of a dying prisoner, the PSIs, PSOs and Prison Rules emphasise security as the primary concern in a number of

[166] Interview 11, Wakefield
[167] Fieldnote, Wakefield, 19/7/2018

situations relevant to the treatment of a dying prisoner. However, understanding these regulations has an importance beyond providing insights into how prisoners should be treated or tasks performed. Carrabine (2000) states: “the penal system can be regarded as a composite of diverse forces, techniques, rationalities and devices which seek to regulate the actions and decisions of individuals and groups in relation to certain authoritative criteria.” He continues, “these criteria and the ability to act are performed through discourse” (p.316). It is argued here that prison ‘rules’ form part of the discourse in prisons about dying prisoners and inform constructions of the dying prisoner. Carrabine (2000) argues discourses structure action, belief and conduct. It therefore follows that the discourses created by the prison rules around dying prisoners, palliative care and responses after a death will shape not just what happens in relation to a specific rule but also attitudes towards dying prisoners more generally. Similarly, the rules applying to the deaths of prisoners are part of a broader framework of beliefs and conduct which are in part shaped by the discourses arising from other regulations. In a setting where “rules may be the anchor in a world of uncertainty” (Liebling and Price, 2003, p.74), it is inevitable they set the tone for how dying prisoners are perceived and treated, although they were “resources upon which to draw, rather than templates to be applied” (Liebling and Price, 2003, p.74).

Most of the relevant attention of the ‘rules’ with regard to dying prisoners is on escorting prisoners to hospitals outside the prison, either to out-patient appointments, for in-patient treatment or as emergency cases. These situations may occur repeatedly for a prisoner with a terminal diagnosis or at the end of life. By far the highest number of references within the ‘rules’ with regard to prisoners receiving treatment in outside hospital relate to managing security risks as opposed to aspects of their care. Identified risks include escape, threats towards healthcare staff or members of the public, and media interest.[168] Treating prisoners in outside hospital is seen as something that should be minimised since it poses a security risk and causes “considerable operational pressures on the prison”[169] because of the need to provide escorting prison officers.

When treatment in an outside hospital is unavoidable, PSI 33/2015 requires a minimum escort of two officers, possibly more depending on the outcome of a risk

[168] PSI 33/2015, Section 6
[169] PSO 3050, 4.1

assessment.[170] On all of the 'bedwatches' observed as part of this research project, two prison officers were present.[171] The details of the risk assessment for all prisoners are specified in PSI 33/2015. This should include the prisoner's medical condition, their security category, their offending history and prison record, any available intelligence, their motivation to escape and likelihood of having outside assistance to do so.[172] It is stated that factors such as advanced age, infirmity or chronic health conditions should be considered and may reduce the need for restraints.[173] When discussing risk assessments for the use of restraints, officers, senior managers and healthcare staff participants all emphasised the prisoner's infirmity, framing this as whether he had sufficient mobility to escape.[174]

The 'rules' specify the particular duties of the officer in charge of the escort, including familiarisation with the route, searching the prisoner and preparing an escort bag which includes suitable restraints.[175] PSI 33/2015 specifies the actions of officers once at the hospital, such as escort staff not normally accompanying a prisoner into the operating theatre, unless there is an assessed need for them to do so.[176] With regard to hospital admissions ('bedwatches'), there are specific requirements for record keeping[177] and for the equipment (such as plastic cutlery and nightclothes) that the prison should provide for the prisoner.[178] There are also regulations covering visits from other prison staff such as chaplains,[179] and any family visits.[180] In the case of a prisoner being escorted to hospital in an emergency, the 'rules' specify the usual risk assessments prior to an escort can be delayed, but must be completed as soon as possible.[181] Should emergency treatment such as defibrillation be required, escort staff are mandated to comply with any medical practitioner's request to remove the restraints immediately, and inform the duty governor as soon as possible afterwards.[182]

A number of references are made to record keeping, often as part of demonstrating the management of risk. A Person Escort Record (PER) is regarded as the:

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[170] PSO 33/2015, 6.5, 6.6
[171] Fieldnotes, Leeds, 26/6/2018, 10/7/2018, 10/7/2018b; Wakefield 19/7/2018
[172] PSI 33/2015, 6.7
[173] PSI 33/2015, 6.8
[174] Fieldnotes, Leeds, 26/6/2017; Wakefield 12/10/2017; Interviews 1, Leeds; 12 & 13, Wakefield
[175] PSI 33/2015, 6.34
[176] PSI 33/2015, 6.15
[177] PSI 33/2015, Section 3
[178] PSI 33/2015, 6.37
[179] PSI 05/2016, PSI 33/2015
[180] PSI 33/2015
[181] PSI 33/2015, 5.12
[182] PSI 33/2015, 5.9, 6.14

key document for ensuring that information about the risks posed by prisoners on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody.[183]

It is the duty of the officers accompanying the prisoner to keep the PER updated with information about the prison staff on duty, any visitors, and at least once an hour, check and record that the restraints have not been tampered with. If the restraints are removed, the prison officers should record in the PER the reason, the time and the name of the person authorising their removal.[184] Record keeping was observed as part of all the 'bedwatches' attended, with the senior escorting officers usually delegated the task.[185]

All of this meticulous detail serves to emphasise the prisoner is being constructed as a potential danger, as someone who poses a risk that must be managed at all times. The 'rules', which officers are expected to be familiar with, also form a discourse which shapes the actions of staff, particularly prison officers. In the 'rules', only when they are unconscious, on the operating table, or requiring extreme treatment such as defibrillation (itself a risk to any officers attached to the escort chain) can the level of security assessed to be appropriate be relaxed. The dominance of this agenda inevitably influences discourses about dying prisoners.

The most visible representation of security considerations was the use of restraints when prisoners were escorted to outside hospitals. The stigma embodied in this was discussed above. The appropriate use of restraints in terms of an assessed security risk was an important part of how staff considered their responsibilities to dying prisoners. On occasions, staff were unhappy about the use of restraints, with both officers and nursing staff expressing dissatisfaction with risk assessments resulting in the use of restraints on prisoners felt to be too frail to escape or unlikely to pose a risk. Nursing staff reported having to 'fight' the prison over this issue.[186] Their unease is reflected in a report from the Prison and Probation Ombudsman for England and Wales (2013) which looks at lessons to be learned from investigations into end of life care in prisons:

While a prison's first duty is to protect the public, too often restraints are used in a disproportionate, inappropriate and sometimes inhumane way (p.5).

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[183] PSI 33/2015, 3.2
[184] PSI 33/2015, 6.36
[185] Fieldnotes, Leeds, 26/6/2018, 10/7/2018a, 10/7/2018b; Wakefield, 19/7/2018
[186] Interviews 1, Leeds; 12 Wakefield

The question of when it is appropriate to use restraints on a terminally or seriously ill prisoner was subject to a high court ruling, the Graham Judgement, implemented via PSI 33/2015, and one of the reasons why staff placed so much importance on the appropriate use of restraints. The importance of this judgement in constructing the dying prisoner was reflected in the fieldwork, with two interviewees, both prison governors, referring explicitly to the Graham Judgement, and the importance of correctly implementing the ‘rules’ on the use of restraints.[187] A further two interviewees, both experienced officers, also talked about the need to be aware of the ‘rules’ regarding cuffing arrangements when accompanying a prisoner while at outside hospital, and of the importance of contacting the prison to review cuffing arrangements if the prisoner’s condition changed[188]. In this respect, the Graham Judgement encouraged officers to openly reassess the construction of the prisoner as he approached death, to consider it possible he no longer posed the same risk.

In his ruling in 2007, Judge Mitting found that:

> *The unnecessary use of handcuffs on a prisoner who is receiving treatment, whether as an in-patient or an out-patient, at a civilian hospital is capable of infringing art[icle] 3 [of the European Convention on Human Rights] in two respects: either because it is inhuman or because it is degrading, or both. The use of handcuffs to guard against an adequately founded risk of escape or of harm to the public in the event of escape does not infringe art[icle] 3. (Item 27)*

Key to his judgement was the notion that restraints should only be used if the risk of escape, or of harm to the public occurring if the prisoner did escape, had been adequately assessed and was well founded. It is the routine use of handcuffing, without an assessment of individual risk, which the judge found likely to be unlawful use if the risk of escape or harm to the public had been adequately assessed (Robinson, 2019). In this respect, the judge was emphasising the need to regard the prisoner as in individual, not as a member of a stigmatised group. With regard to situations where it would be impossible for the prisoner to escape, the judge found handcuffing him would be unlawful and a breach of article 3 of the ECHR:

> *A dying prisoner, properly assessed as posing a risk of escape when fit, and a risk of violence to the public were he to escape, could properly contend that handcuffing him during his dying hours was nonetheless an infringement of his right not to be treated inhumanely or in a degrading manner. (Item 27)*

[187] Interviews 7 &13, Wakefield
[188] Interviews 11, Wakefield; 2, Leeds

At HMP Wakefield, a pro forma had been created to assist with decisions about using restraints.[189] The Graham Judgement served as an encouragement to ensure legal requirements were met, reinforced by an awareness that the prison would be criticised by the PPO after a death if restraints were found to have been incorrectly used.

The deprivation of autonomy

In his seminal study of a 1950s American maximum security prison, Sykes (1958) identifies the deprivation of autonomy as one of the five pains of imprisonment. For him, this is defined as resulting from the prisoner's subjugation to a "vast body of rules and commands which are designed to control his behaviour in minute detail" (p.73). He suggests that whilst the matters controlled may be trivial, prisoners feel intense hostility at being dependant on the unexplained decisions of people with very different objectives to their own. He argues this lack of autonomy presents a psychological challenge to the prisoner, undermining their self-image by reducing them to "the weak, helpless, dependent status of childhood" (p.75). Sykes suggests the prison custodians in his study avoided giving explanations in order to prevent prisoners being able to present an alternative viewpoint and challenge the rules, which is echoed by Goffman's (1961) claim that "characteristically the inmate is excluded from knowledge of the decisions taken regarding his fate…. Such exclusion gives staff a special basis of distance from and control over inmates" (p.19–20). With regard to prisoners dying of natural causes, Aday (2006) states that "in an institution such as a prison, which controls living as well as dying, a sense of helplessness is almost unavoidable" (p.201). A lack of autonomy is also characteristic of the healthcare available to prisoners, with Bolger (2005), Turner, Payne and Barbarachild (2011) and Condon et al. (2007) all suggesting prisons allow prisoners very little personal choice regarding healthcare. This lack of autonomy is inextricably linked to the individual's status as a prisoner.

When some limited autonomy was available to a dying prisoner, it was noteworthy. In HMP Wakefield, staff in a variety of roles repeatedly referenced Eddie as a prisoner whose wishes had been respected.[190] During the last few months of his life, he had expressed a wish to be accommodated on the wing rather than in the

[189] Interview 13, Wakefield
[190] Fieldnotes, Wakefield, 23/11/2017, 30/11/2017, 14/11/2017, 14/11/2017b, 7/11/2017, 13/12/2017, 1/2/2018; Interviews 13 & 15, Wakefield

healthcare centre as was expected. A number of staff, nurses and officers reported they wouldn't force him to move cells[191] and expressed satisfaction that the wing was the best place for him because it was what he wanted.[192] The exercise of autonomy by a dying prisoner was however, not without contest or concern. When asked if they could compel Eddie to move to healthcare, another senior officer was clearly reluctant to do so, but would not rule out the possibility.[193] As he grew more obviously frail, staff concerns about Eddie's location intensified and the commitment to facilitating his wishes diminished. Even before this, Eddie's options were limited. When a fall in his cell resulted in staff wanting him to be in a cell with a bell by the bed, he was consulted, but his options framed as moving cell on the wing or going to healthcare. Staff knew he was aware he was not being given a choice.[194] Interestingly, no other cases in HMP Wakefield were offered as examples of prisoners being granted such autonomy. It was not clear whether this was because it had not occurred, or had happened but subsequently been forgotten. One officer who was interviewed talked about being sensitive to the needs of another prisoner accommodated in the healthcare centre towards the end of life, albeit on a less significant issue:

> *Y'know some days he'd come and sit and eat a little bit at table, er, and some days he didn't even want his tea. So it were just, we kind of let him lead, if you know what I mean, and we just worked round him.*[195]

Other prisoners recounted similar narrow choices being offered to their peers, with one saying the withdrawal of medication was used as a 'threat' to get unwell prisoners to move to the healthcare centre.[196] Location in the healthcare centre was recognised to make the administering of medication easier for a variety of reasons, but prisoners clearly saw this 'threat' as another way of minimising their agency.

The construction of dying prisoners in relation to their entitlement to autonomy was slightly different at HMP Leeds, where there were more examples of granting autonomy, including to Dean, who had similarly had his wish to stay in the wing after a terminal diagnosis respected and was only relocated to H3 when he said he wanted to move.[197] Furthermore, a nurse at HMP Leeds talked about meeting a

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[191] Fieldnotes, Wakefield, 23/11/2017, 30/11/2017
[192] Fieldnote, Wakefield, 14/11/2017
[193] Fieldnote, Wakefield, 1/2/2017
[194] Fieldnote, Wakefield, 13/12/2017
[195] Interview 15, Wakefield
[196] Fieldnote, Wakefield, 3/11/2017
[197] Interviews 1 & 3, Leeds

dying prisoner's wishes in other ways, saying they would ensure his friends were present even though it was late at night, or arrange for him to see a particular film if he wanted.[198] Small concessions were seen as significant. An officer here spoke about the importance of giving prisoners the choice as to whether to have their cell door open or closed during unlock periods, a means of them controlling which prisoners came into their cell.[199]

With Eddie, the source of the decision to move him was less clear to many people, but the agency for the action was attributed to staff, not him. One interviewee said that they 'got him over', meaning moved him to the healthcare centre regardless.[200] Another knew of Eddie's case, but wasn't sure whether he'd died in hospital. When I told him what I knew, the interviewee said 'So they did eventually move him', again attributing the agency for this to someone other than Eddie.[201] Although Eddie was well liked and much sympathy was expressed for him, he could still be talked of as an object to be managed.

Eddie's case also illustrates the limited means by which prisoners could exercise their autonomy at the end of life. Irwin and Owen (2011) regard loss of agency as one of the forms of psychological damage which result from imprisonment and which erode a prisoner's ability to cope with life outside. They point out that with few opportunities to make decisions or exert choice in their daily routine:

> *prisoners steadily lose their capacity to exert power and control their destiny as they serve time in prison. Prison life is completely routinized and restricted* (p.98).

Eddie's ability to control, to small extent, his location within the prison was attributed by staff and prisoners who knew him to his stubbornness,[202] a characteristic that other prisoners associated with a number of their older colleagues.[203] His tools to exert his will were however limited; he was reported to have refused to eat until transferred from the healthcare centre to the wing[204] and then to have lied about his condition, in the opinion of healthcare staff, to avoid being moved back off the wing.[205] Although he had clearly not, as Irwin and Owen (2011) suggest, lost the

[198] Interview 2, Leeds
[199] Interview 3, Leeds
[200] Interview 13, Wakefield
[201] Interview 11, Wakefield
[202] Interview 13, Wakefield; Fieldnote, Wakefield, 15/12/2017
[203] Interview 14, Wakefield; Fieldnote, 14/11/2017
[204] Interview 5, Wakefield
[205] Fieldnote, Wakefield, 9/2/2018

habit of agency, he had few resources to use in a situation where the power relationships were stacked against him. What seemed more significant in explaining why he was afforded some autonomy was the fact he was liked and respected by officers, who expressed sympathy for him.

5.5 Seeing the 'patient' or 'person'

A terminal diagnosis and the approach of the end of life made it more likely for a prisoner to be constructed as 'patient' or 'person' by staff in all roles. Although these terms were used predominately by healthcare professionals and chaplains, in the face of a terminal diagnosis officers also described a softening of the usual distinctions between their position and that of the prisoner, and a greater awareness of the individual as a fellow human being. Key to this experience were feelings of sympathy towards the individual provoked by their failing health, although not in all circumstances. An impending death also brought prison officers and other staff into unexpected contact with the prisoner's family, potentially leading to new constructions of the individual as part of a family, emphasising they were someone with links beyond the prison wall, rather than solely a prisoner. Again, these constructions influenced the care prisoners received, and impacted on the regime and the relationships and culture within the prison.

Sympathy

The fact of imprisonment when dying was for some staff, especially those not working as prison officers, itself a reason for sympathy and a softening of attitudes. One of the healthcare team at HMP Leeds felt if other staff were more conscious that dying in prison was unpleasant, and more aware of the restrictions placed on the prisoner even though he was dying, they would be more understanding. Prison was seen as a hard place to be, even if not ill, and so much harder for the dying.[206] A prison chaplain at HMP Leeds keenly felt the loneliness of dying in prison:

> *When a person passes, if they've got the family around them, erm, or if they've died with the support of the family around them, erm, you get, you get a sense, of feeling that that person died knowing that they were well loved, y'know? But when a person dies in prison, even though, obviously, it's not the prison's fault that they're here in the first place, I think as a human being, there*

[206] Interview 1, Leeds

is this thought in my head that that person has died on their own, y'know, there was no one there.[207]

For this chaplain, one of the main regrets about someone dying in custody was the lack of family support they would receive. They may in practice be accompanied by officers or nursing staff at the moment they died, but without his family, the prisoner was in the eyes of the chaplain 'alone'. His comment highlights the lack of love that a dying prisoner would experience, and a deep compassion for them stemming from the awareness they would probably die without their family. For many healthcare staff and for other chaplains, concerns that a prisoner would die alone contributed to generating sympathy for their situation.[208] As one nurse said, equating prisoners to people in general, "nobody wants to die alone".[209]

In terms of the relationships between prison officers and prisoners, Arnold (2016) suggests prison officers are trained to see these relationships as procedural and instrumental, achieving something in line with the prison officer's and prison service's agenda. However, when a prisoner was known to be dying, the relationships between them and many staff, including some prison officers, were marked by sympathy towards the prisoner. Prison officers undertook considerable emotional labour and expressed a seemingly genuine sympathy for the prisoner at being in the situation of dying in prison, especially if the prisoner was young or liked and respected for behaviour transcending the usual expectations of staff. Any instrumental nature to the relationship was less apparent. Additionally, far from the retributive culture sometimes attributed to prison officers (Crawley, 2004), officers often felt that when a prisoner was dying they were expected to feel forgiveness and sympathy. This was particularly striking in the instance quoted above, where a female officer's repulsion for prisoners who had harmed children meant she felt unable to experience the sympathy she regarded as required by her occupational culture. The officer was clear she needed to hide from her colleagues her lack of sympathy and performed the necessary 'surface acting' to demonstrate the expected 'feeling rules' of her role.[210]

Other officers regarded maintaining a distinction between themselves and a prisoner as part of being professional but, if a prisoner was terminally ill, experienced a softening of this difference. They were aware their officer colleagues could struggle

[207] Interview 8, Leeds
[208] Fieldnotes, Wakefield, 8/2/2018, 9/2/2018; Interviews 5 & 12, Wakefield
[209] Interview 12, Wakefield
[210] Interview 15, Wakefield

to feel the sympathy now regarded by them as an expected part of their professionalism. Prison officers could feel required to perform the deep acting of allowing a terminal diagnosis to provoke a sympathetic response in themselves:

> *Me, me personally I would do it in a professional way that he's still a prisoner, I'm still an officer, but there's an element of you've got to feel sorry for them because they are dying. So, but not everyone can do that because of the nature of what they have done.*[211]

Such comments show an awareness of the complexity experienced by officers in feeling sympathy for a prisoner. They illuminate the tension inherent in recognising the prisoner's humanity whilst maintaining the dynamic expected to exist between an officer and a prisoner. The 'feeling rules' of the prison officer's role required professionalism, including sympathy, which for some was 'surface acting'. Significantly, the humanity of a prisoner became more apparent to a prison officer when there was a terminal diagnosis. This could influence the prisoner's care, leading to adaptions in the prison regime discussed further in chapter six:

> *It becomes more of a human nature than an officer-prisoner and you maybe do things, not wrong, not, not legally wrong, but for support of the person who is going to pass away.*[212]

There were several examples of how knowledge that a prisoner was dying did seem to subtly change their relationship with staff, encouraging sympathy and making it easier for officers to see a 'person' rather than just a 'prisoner'.[213] One senior officer said:

> *That's where the decency part comes in I think. You've still got to maintain the fact that yes it's a prisoner and you know the fact that you've got to keep that prisoner within this environment, but you know that you make it as easy as possible for them, because you know that that is the last part of his life. Y'know. You will make it as comfortable for them as you possibly could, or possibly can.*[214]

This was not universal. Two officers were observed passing the time during a 'bedwatch' in a conversation, overheard by the prisoner, in which they both

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[211] Interview 11, Wakefield
[212] Interview 11, Wakefield
[213] Fieldnote, Wakefield, 19/7/2018
[214] Interview, Wakefield, 19/4/2018

emphasised not caring about prisoners, not thinking about them after work and in which one of them in particular spoke about prisoners he found unpleasant and even about being impatient for a prisoner to die during a previous ‘bedwatch’. Nevertheless, the officer expressed sympathy for a prisoner he had escorted to a hospital appointment where he had been given a terminal diagnosis:

> *He says it felt like the man had been “given a kick in the balls”, and then apologises for swearing. He says this time he did talk about it at home.*[215]

Crawley (2004) is thus correct in suggesting there are organisational norms for prison staff expressing sympathy but the fieldwork in this study does not support her claim prison officer culture forbids expressions of sympathy for prisoners, or that sympathy is not likely to be expressed in the hearing of other officers. In this study, a terminal diagnosis often resulted in an expectation amongst prison officers that sympathy would be shown to a prisoner. What is significant is how some officers struggled to meet this expectation when the prisoner was doubly stigmatised by having committed sexual offences or crimes against children.

The nature of a prisoner’s offence could also positively influence attitudes towards them at the end of life and make it more likely they would be viewed sympathetically. An example was given in HMP Leeds as an illustration, with the suggestion that a shoplifter, first time in prison, would probably be released on licence to the hospice.[216] A more sympathetic treatment could be afforded to him because his crimes were regarded as minor. Remand prisoners, typically only accommodated at HMP Leeds, provoked further sympathy. One of the healthcare staff at HMP Leeds spoke of her anger after the death of William, an elderly remand prisoner whose dementia meant he was in her opinion unaware even that he was in prison. He died before being convicted of any crime, in her eyes therefore an innocent man, and she was furious when:

> *the actual <u>vicar</u> in the service made comments of “Well it’s a shame really, because this congregation would have been really full had it not been for his crimes”.*[217]

She felt an injustice was being done to the deceased prisoner and that, because he had not been convicted, a stigma had been incorrectly applied to him.

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[215] Fieldnote, Wakefield, 19/7/2018
[216] Interview 1, Leeds
[217] Interview 10, Leeds

Age could also invoke sympathy, with staff displaying more regret at atypically early deaths. This reflects the assumption, discussed earlier, that deaths from natural causes would be associated with ageing. Dean, who had stayed on the wing in HMP Leeds after his terminal diagnosis, stood out for interviewees because of his age.[218] The behaviour and demeanour of the prisoner, both before and after a terminal diagnosis could also dramatically influence the extent to which sympathy was expressed to them, and indeed how care was performed. The healthcare worker at HMP Leeds who spoke about William said: "I liked him. Regardless of what crime he'd done, he was lovely man".[219] His putative crimes were not an obstacle to her favourable opinion.

Eddie was another good example of this. Officers in HMP Wakefield were clear "he's no trouble, doesn't make extra demands on staff, isn't on his bell"[220] and that he was a "decent prisoner".[221] There was a slight hesitation and awkwardness about the use of this latter term in front of me, an awareness it was a term used amongst themselves that might not be politically correct to the researcher and that he had earned the epithet of "decent prisoner" because they had not had to do much for him. Crawley (2004) suggests officers more readily feel sympathy for a cooperative rather than a disruptive prisoner, and this was the case with Eddie. Opinions towards him also seemed to be influenced by his attitude towards his terminal illness. He was described as having been "positive", not moaning or playing on his diagnosis for more attention, which garnered respect because it was atypical of many prison officers' expectations of prisoners.[222] He was also popular, liked by his peers on the wing, with friendships in which his support for others was now being reciprocated.[223] In his uncomplaining approach to his terminal illness, Eddie was seemingly enacting something both convenient and inspiring for staff and peers around him. In a similar way, another prisoner who had had a stroke was spoken of fondly by a peer. The man was regarded highly because he kept cheerful, and although he only had two words, made people laugh.[224] Liebling, Price and Shefer (2010) talk about different forms of respect in prison, suggesting that whilst fear and power can gain respect for staff and prisoners alike, respect also derives from the individual stepping out of the limitations and expectations of their role and showing

[218] Interviews 1 & 10, Leeds
[219] Interview 10, Leeds
[220] Fieldnote, Wakefield, 1/2/2018
[221] Fieldnote, Wakefield, 30/1/2018
[222] Interview 5, Wakefield
[223] Fieldnotes, Wakefield, 28/11/2017, 23/11/2017, 29/11/2017, 30/11/2017, 7/11/2017
[224] Fieldnote, Wakefield, 14/6/2018

moral strength. It is arguably in these latter regards that Eddie and the stroke survivor earned respect.

Those prisoners who were less popular were less likely to provoke sympathy. A member of staff, when asked about the impact on prisoners in H3 if one of their number needed to go to outside hospital said that in the case of a man who had been taken out the day before, not expected to live, it had had no effect: he had not been there long and was not liked.[225] A prisoner in HMP Wakefield, in contrast to Eddie, but who had been on the same wing, was reported to be disliked because he and his cell were unhygienic, and the prisoner-carers cleaning for him were frustrated by his habits.[226] His diagnosis did not favourably change the relationships he had with those around him.

Constructing the family man: the influence of a prisoner's family

A terminal diagnosis or a death from natural causes frequently brought prison staff into contact with the prisoner's family in ways that would not otherwise have occurred. Central to this was the work of the family liaison officer (FLO), whose role was to be a contact point between the prison and the prisoner's family, providing information and support to the family (Bending and Malone, 2007). The FLOs who participated in this research project all expressed sympathy for the families. They saw their role as helping the family at a difficult time[227], and as making things as straightforward as possible for the family.[228] Arguably, this interaction with prisoners' families also influenced the construction of the dying prisoner, situating an individual in relation to a group of people who were not incarcerated, reminding staff of their connections beyond the prison and of identities other than 'prisoner'. This could serve to enhance sympathy for the prisoner. However, it was also noticeable that it was often easier for staff to feel sympathetic towards the prisoner's family than towards the prisoner. This sometimes led to adjustments to the physical environment or to routines to support prisoners' families which also served to better meet the needs of the dying prisoner. Seeing the prisoner as someone's relative could result in adaptions to the regime and changes to relationships within the prison.

[225] Fieldnote, Leeds, 16/2/2018
[226] Fieldnote, Wakefield, 18/12/2017
[227] Interviews 15, Wakefield; 16 Leeds
[228] Interview 15, Wakefield

Sympathy was extended to the family, by FLOs and other staff, for several reasons. In HMP Wakefield in particular, families were seen as having been negatively affected by the crime. They were described as the “innocent party” and it was recognised that the crime could split families, disrupt lives and place a stigma on the prisoner’s family.[229] Deaths could also leave unanswered questions for family members, relating to the original crime, and staff felt sympathetic about this. One governor saw deaths as leaving unanswered questions which they could imagine sharing in similar circumstances:

> *There’s always those questions, “what did we do wrong, as a family”. And that could be any one of us, it could be any one us that are left asking those questions: “If I’d have done so and so, would it have changed”. And I’ve found that quite a bit with the families, when you speak to them … that’s the question they want to know. Why? What made them do what they did?... One guy murdered his wife, and his brother actually said, he said, “He was part of the family firm, what went wrong?” He said “We’d been at a family do. He’d gone to bed early. They’d had a fall out. He murdered her”. He said “I just don’t know what went wrong with my little brother”.*[230]

Accounts such as this served to emphasise the humanity of the prisoner as someone’s ‘little brother’, but also to build an empathetic connection between the staff member and family member. Prison staff could identify with the situation of a prisoner’s relative more easily than with that of the prisoner who had committed an appalling crime.

The repulsion felt towards prisoners who had committed sexual offences was mirrored in the tremendous sympathy expressed by staff for victims within the family. The encounters with this side of the prisoner’s story resulting from their death could be profoundly affecting:

> *when they went, the staff went down, all the daughter wanted to know was “was there anything that could have been passed on to her and her daughter from the father?”. Was there any illness we could tell them, which we couldn’t. Erm, and then she proceeded to tell them of the things the father had done.*

[229] Interview 15, Wakefield
[230] Interview 13, Wakefield

> *And I know both FLOs, both female FLOs, had to stop the car on the way back and just sat and sobbed.*[231]

The challenges presented by such deaths in terms of supporting members of staff involved with the family will be discussed in the next chapter.

Staff had to attempt to contact a next of kin when a prisoner was dying, with his permission, or after an unexpected death. Given the sexual nature of the offences of many prisoners at HMP Wakefield, staff were understanding when a family chose not to have anything to do with them, although this placed more pressure on the prison in terms of taking responsibility for the practicalities of arranging the funeral.[232] When there was family involvement, there was concern for the family facing a more complicated bereavement process because of their family member's imprisonment.[233] It was recognised that families would not be able to plan the funeral in the usual way because of the investigations following a death and that they would need regular contact in order to get through the process that followed a death.[234]

FLOs in particular often built close relationships with the prisoner's family, maintaining contact over a number of weeks. They got to know about the family's financial circumstances, helping out with taxi costs[235], talked about their employment[236] or simply chatted in general terms.[237] This could present difficulties, as in one case where a FLO subsequently needed to contact the police about the prisoner's wife's possible criminal activity.[238]

Staff expressions of concern for the family of a dying or deceased prisoner seemed to serve a number of purposes. Often, staff felt they could identify with the family more than the prisoner. This was especially the case where the additional stigma associated with certain abhorrent crimes could make identification with the prisoner deeply uncomfortable and sympathy hard to generate. Most significantly, by foregrounding the involvement of the family, some prisoners could be seen as 'family men'. For example, in talking about Dean, a young prisoner from HMP Leeds, nursing staff emphasised he had a wife and child, and expressed concern

[231] Interview 13, Wakefield
[232] Interview 15, Wakefield
[233] Interviews 8, 16 & 1, Leeds; 15 & 4, Wakefield
[234] Interviews 15, Wakefield; 16, Leeds
[235] Interview 9, Leeds
[236] Interviews 2 and 16, Leeds
[237] Interviews 7, Wakefield; 9 Leeds
[238] Interview 16, Leeds

that the nature of his death had been distressing for them. They recounted having had considerable contact with his family during his illness because they had visited him in H3. Dean was constructed as a family man who wanted to fulfil the responsibilities of this role:

> *his little son, erm, he was a little superstar, he was so brave, so brave, and all he wanted was a new bike. And all Dean ever talked about was "I wish I wasn't in here so I could get him a bike"*[239]

After his death, prisoners from Dean's wing raised money to buy his son a bicycle.[240]

How dying prisoners were constructed in relation to their family had an impact on the sympathy afforded to them and arguably introduced a different construction of the individual as part of a family, not solely a 'prisoner'. It also resulted in some adjustments being made to their care. Most commonly this led to family visits in areas of the prison not normally accessed by visitors, especially the healthcare centres, when the prisoner lacked the mobility to access the Visits hall. Both HMP Leeds and HMP Wakefield facilitated visits in locations other than the Visits hall when deemed necessary, even though this caused some practical difficulties.[241] Sympathy for families was also a significant motivation for prisoners, healthcare professionals and other staff in the seeking to create pleasant palliative care suites in both of the prisons, discussed in chapter four, something which also benefitted prisoners.

One of the more significant adjustments resulting from constructing the prisoner as a family man occurred in HMP Wakefield. The wife of a prisoner, Neil, had been permitted to stay overnight with him in the healthcare centre when his death was imminent. Staff in all roles regarded it as a highly unusual move, especially in a high security prison, and it was not without controversy. There was also considerable pride amongst staff that it had been possible to do this, and a conviction it would happen again in future cases.[242]

> *It was such a huge thing for her to be able to spend the night there with her husband, y'know the staff tried to make it as comfortable as possible for her*

[239] Interview 10, Leeds
[240] Interviews 1 & 10, Leeds
[241] Interviews 1, 2, 3, 10, 9, 16, Leeds; 13, Wakefield
[242] Interviews 12, 13, & 7, Wakefield

> *and she got to be there while her husband passed away. So it were really, she were so grateful for that.*[243]

It had only been considered because Neil's wife was liked by staff, not seen as likely to cause any problems. Despite that, staff were still present, and their presence attributed to a need to make sure she didn't hasten his death.[244] Neil's status as a dying prisoner had been established before his arrival in the prison. He had been transferred to HMP Wakefield to be nearer his family because he was known to be dying. As such, his wife was already prefigured as his widow when he arrived, and the sympathy extended to her doubtless reflected this. Extending sympathy to the family, or displacing it to the family if the prisoner was beyond sympathy, led to other new tasks for prison staff, which will be discussed in chapter six in connection with the performance of care.

5.6 Constructing the dead prisoner

The constructions of dying prisoners used by officers, healthcare professionals and other staff continued to be relevant after a prisoner's death from natural causes, whether the death was anticipated or not. These constructions informed assessments of whether or not it was appropriate to feel grief for the deceased and influenced how the body was treated and disposed of after death, including what memorialisation was judged relevant. Death may be a great leveller, but in many regards the status of the deceased as a former prisoner could not be overlooked.

The status of the dead prisoner's body

Immediately after any death in prison custody, the location of the death was regarded as a potential crime scene, sealed off pending a police investigation. PSI 64/2011 mandates that "all deaths in custody are treated as suspicious by the police"[245] and details the actions that must take place to facilitate the investigation. The expectation that all deaths will be investigated reflects the importance placed on security within the prison. Commenting on how this affected her nursing, one healthcare professional said:

> *That's the one thing that I find quite strange because when you're in hospice and on a ward we do the last offices and we wash them, wrap them up. Here, when they die, you just leave them. And that's quite difficult, because you just*

[243] Interview 15, Wakefield
[244] Fieldnote, Wakefield, 5/12/2017; Interviews 7 & 13, Wakefield
[245] PSI 64/2011 Chapter 11

> *think, "no, I need to get him sorted out". But because it's a crime scene, as soon as they have died, you have to come out.*[246]

The impact this had on the provision of care will be discussed later, but it is clear there is a distinction between the body of the deceased prisoner and that of people who die in the community. Once a death has occurred in the prison, the fact of the investigation reconfigures the prisoner, formerly seen as someone who has committed a crime, into someone who was potentially a victim of a crime.

In other ways, the deceased prisoner could continue to be affected by the status accorded to them during their life. It was notable that in some circumstances, the deprivation of autonomy associated with imprisonment (Sykes, 1958) could continue after death. When prisoners were planning ahead, telling staff how they wanted their remains to be handled, staff had on occasions to tell them that because they were a prisoner, their plans would not be possible.[247] Prisoners without a next of kin could not be cremated, even if they had expressed this wish before death, in case family members later contacted the prison service to claim the body.[248] In this way, the deceased prisoner was reconfigured as a member of an unknown family who might become known in the future.

Grievable or not?

The importance of constructions of the prisoner after their death was also evident in whether or not they were regarded as 'grievable'. Butler (2016) says, "only under conditions in which the loss would matter does the value of life appear. Thus grievability is a presumption that life matters" (p.28). In the context of attitudes to deceased prisoners, the converse was seen to be sometimes true; if a loss of life was not defined as 'grievable', then that life could be seen not to have mattered, or at least not to have mattered as fully as other lives.

Prisoners were very alert to this, seeing examples of their deceased peers being treated as 'ungrievable' as indicative of the low value placed on the lives of those who survived.[249] They were highly critical of actions such as not putting a screen in place after a sudden death or leaving a wrapped body where it was visible to prisoners looking through the cracks in their cell doors[250], desiring that their dead

[246] Interview 12, Wakefield
[247] Interview 5, Wakefield
[248] Fieldnote, Wakefield, 23/3/2018; Interviews 13 & 5, Wakefield
[249] Fieldnotes, Wakefield, 10/1/2018, 14/11/2017
[250] Fieldnote, Wakefield, 21/11/2017

peers should not provide a spectacle for others. Prisoners also regarded delays in arranging memorial services in the prison chapel or errors in the information about such services as unacceptable.[251] These incidents offended a sense of what it was to treat someone with respect after death. They were interpreted as demonstrating the deceased was not valued by the staff responsible for making arrangements, by implication because the deceased had been a prisoner. It was felt that if staff did not show respect after death to someone who had been a prisoner, there was little hope of it being available to prisoners during their incarceration. When prisoners thought officers regarded the deceased as simply 'one off the roll', they equated this with themselves being 'ungrievable' and unvalued.[252]

Prison chaplains at HMP Wakefield made a similar comparison to that of prisoners, interpreting the failure of officers to attend memorial services within the prison as indicative of a lack of value placed on the life of the individual who had died.[253] Staff in other roles contextualised prison officers' attitudes to deceased prisoners as part of a traditional 'macho' occupational culture, not limited to male officers, which meant grief at the death of a prisoner was not shown.[254] It was rare for officers to visibly behave in a way which might suggest to their colleagues they were grieving for a prisoner, or imply that they were paying their respects for him. When they did so, they could find themselves being criticised. One officer spoke about a colleague who had gone off sick after a prisoner had died, saying "he got a ribbing for it".[255] Another officer at HMP Leeds had attended a memorial service within the prison for a prisoner whose death was self-inflicted. He said it had been a lovely service, and had stayed to talk with the prisoners who had attended. However, he was aware how exceptional his attendance was, rooted in his own willingness to subvert or ignore occupational norms: "He said staff don't go because they fear being criticised for being there by colleagues — but he doesn't care".[256]

At HMP Wakefield, a member of staff reported telling prisoners about an officer who had driven colleagues to Eddie's funeral who were required to attend and had asked if he could also be at the graveside during the service to pay his respects. The member of staff had been touched by this, and said that when he had mentioned the incident to prisoners who had known Eddie, they had said "can you tell us who it is

[251] Fieldnote, Wakefield, 20/3/2018
[252] Fieldnotes, Wakefield, 14/6/2018, 7/2/2018
[253] Fieldnote, Wakefield, 3/11/2017
[254] Fieldnotes, Wakefield, 19/11/2017, 3/11/2017
[255] Fieldnote, Wakefield, 7/12/2019
[256] Fieldnote, Leeds, 10/7/2018

so we can shake his hand?".[257] Both the staff member and the prisoners he shared this experience with regarded it as unusual for an officer to seek to pay his personal respects in this way. It was a measure of the esteem in which Eddie was held that the officer was willing to deviate from occupational norms, albeit in a setting where very few colleagues were present.

In contrast, officers themselves said it was impossible not to feel some emotion at a death[258], especially in HMP Wakefield, where there were a large number of long-term prisoners and long-serving officers:

> *If we've had staff who have been here 30 years plus, and they'll have, they'll have known that prisoner for all that length of time, worked with them, they'll be on first name terms, whatever. And it, it will affect people.*[259]

This is in keeping with Crawley's (2004) suggestion that there is inevitably a degree of intimacy between prison officers and prisoners, especially when the prison officer has worked with the same prisoner through a variety of difficult and disappointing experiences in their sentence.

Officers and senior managers were aware officers were often criticised for not showing grief but contested the idea that this was the case for most officers: "Y'know everybody is different, some, it's just a number, but it's not as a rule".[260] It was accepted there were differences in how officers were affected by a death[261] and that they had different strategies for dealing with emotions after a death.[262] Some at least said they remembered the face of every prisoner they had worked with who had died.[263] It was however striking that the emotional labour of prison officers was often in the context of needing to maintain face or perform protective deep acting in light of the challenges arising from working with death and dying, not in response to grief at an individual prisoner's passing. The emotional challenges associated with working with dying prisoners were typically the result of being reminded of the deaths or illnesses of family members, or of being in an unfamiliar situation.[264] The emotional labour of individuals is not directly relevant to the research questions of this study, but the ways in which the care needs of prison staff working with dying

[257] Interview 5, Wakefield
[258] Interview 11, Wakefield
[259] Interview 7, Wakefield
[260] Interview 13, Wakefield
[261] Fieldnote, Wakefield, 7/12/2017
[262] Interviews 2, Leeds; 11 & 6, Wakefield
[263] Interview 6, Wakefield
[264] Interviews 16, Leeds; 13, Wakefield

prisoners impacted on the culture and relationships within the prison will be discussed in chapter six.

Experiencing and expressing grief for a deceased prisoner was more acceptable amongst healthcare staff. The different dominant status awarded by healthcare staff to the terminally ill individual was again apparent. Healthcare professionals spoke about forming a bond "as if they are a 'normal' patient"[265] and in Neil's case, the presence of his wife at his bedside in HMP Wakefield at the end had heightened their emotional responses.[266] Nursing staff at HMP Leeds attended every funeral for prisoners they had cared for, even though this could be quite emotionally taxing. Attending the funeral was also seen as a form of supporting the prisoner's family.[267] This was in contrast to their actions in previous nursing roles in the community, but indicative of the closer bonds they had formed:

> *I don't know, I just feel, because I've looked after them for so long, and I know their family, I just think it would be wrong not to go. I mean on the community we rarely went, but on here, I know it sounds really lame, but up here especially, it is like a family up here.*[268]

Again, the relationship with the prisoner's family was important in shaping how staff regarded prisoners. Furthermore, constructing the dying individual as a 'patient' rather than as a 'prisoner' can be seen to have a lasting effect, influencing a relationship extending after death. It results in the individual being seen as a 'grievable' patient rather than a prisoner unworthy of such emotion.

Staff and prisoners spoke about the impact on other prisoners of a death. Aday and Wahidin (2016) say that "losing close friends in prison may also be a harrowing experience for prisoners who frequently establish close kin relations with prison peers" (p.318) since long-term prisoners share space and activities with other prisoners. Staff recognised that in HMP Wakefield, where prisoners could have been neighbours on the wing for many years, a death would have an effect, even if prisoners would not admit it.[269] Other staff felt the impact of a death would be limited to only prisoners who had been close to the deceased.[270] This was in one instance explained away by a construction of prisoners as uncaring:

[265] Interview 12, Wakefield
[266] Interview 12, Wakefield
[267] Interview 10, Leeds
[268] Interview 10, Leeds
[269] Interview 13, Wakefield
[270] Interview 6, Wakefield

> *Prisoners are prisoners. Prisoners do their own thing. If a prisoner died on the wing, some of them wouldn't bat an eyelid. It's just, somebody else'll fill that bed tomorrow. It's just the nature of, it's the nature of how prisons work and it's the nature of prisoners.*[271]

In contrast, prisoners themselves gave many examples of grieving for deceased peers. One spoke about having been too upset to eat for a week after the death of a prisoner he was close to, and having struggled again at the anniversary of the death.[272] Another, speaking about two people he had met in prison who had subsequently died, had to acknowledge his eyes were filling with tears as he talked about them.[273]

Memorialising the dead

How the deceased prisoner was memorialised reflected how he was constructed after his death. Prisoners shared the view of staff that the frequent absence of mourning family or friends at funerals was a cause of sadness, a poor return on a life.[274] One prisoner in HMP Leeds reported on a recent funeral he had been told about by staff who attended:

> *He says there were only four people at the man's funeral, and that his wife was dressed like a tramp. His eyes water up and he pauses for a moment before moving the conversation on deliberately.* [275]

Such episodes served to emphasise the individual was not valued by those tasked with memorialising him.

Prisoners knew they could not attend the funeral, held outside the prison, but expected there to be a memorial service within the prison, organised by the chaplaincy team, as part of demonstrating the worth of the deceased. There was also informal memorialisation of deceased prisoners. One prisoner spoke about dedicating a music session to a recently deceased member of the group, joking he had had the worst sense of rhythm.[276] The same prisoner also talked about having fortuitously been in the healthcare dentist's waiting room soon after this death, with other prisoners who had also known the deceased well, and having had valued time

[271] Interview 11, Wakefield
[272] Fieldnote, Wakefield, 21/11/2017
[273] Fieldnote, Wakefield, 29/11/2017
[274] Interviews 13, Wakefield; 1, Leeds
[275] Fieldnote, Leeds, 25/6/2018
[276] Fieldnote, Wakefield, 12/4/2018

to share happier memories informally.[277] In the immediate aftermath of a death, prisoners gathered for other purposes would discuss the deceased, responding with jokes if the atmosphere became too intense. Education was a convenient setting for this, and two staff members talked about occasions when prisoners discussed a deceased prisoner in the classrooms. One reported:

> *Everyone was then quiet for a few minutes, which as you know is rare in that room. It felt as though it all got a bit intense and real for them all because very soon they started to make jokes about it to change the atmosphere.*[278]

The education department was again serving the function of an 'emotion zone' as suggested by Crewe et al. (2013), but even here there were limitations on how much grief prisoners were comfortable showing; the conversation was deliberately moved on when it became too emotionally intense.

Despite these informal occasions being valued by prisoners, there was a strong expectation Chaplaincy would organise a formal memorial service.[279] This was seen as a crucial part of showing the deceased prisoner had value, and was deemed 'grievable'. At both HMP Wakefield and HMP Leeds, family members sometimes attended the memorial service in the prison. In this way, memorial services brought together prisoners and the bereaved families of their former peers in a manner that would not usually be expected. Their presence also reconstructed the deceased prisoner as a family man. Prisoners valued the opportunity to meet the families. One prisoner who had spoken at such a memorial service treasured the card he had afterwards received from the deceased prisoner's brother.[280] Another felt staff had deliberately only told him about a memorial service after the event, and was sad not to have met the prisoner's family; he had done some drawings for them for the prisoner to send out and felt a connection.[281]

Memorial services were not without controversy. At HMP Wakefield, some prisoners felt Chaplaincy took too long to arrange the service[282] and did not do so with enough care, criticising chaplains for getting the deceased's name wrong on a 'sign-up sheet' to attend a memorial.[283] Prisoners were reported to remove 'sign-up sheets' in

[277] Fieldnote, Wakefield, 12/4/2018
[278] Fieldnote, Wakefield, 20/3/2018
[279] Fieldnotes, Wakefield, 12/4/2018, 7/2/2108
[280] Fieldnote, Wakefield, 21/11/2017
[281] Fieldnote, Wakefield, 29/11/2017
[282] Fieldnote, Wakefield, 20/3/2018
[283] Fieldnote, Wakefield, 12/4/2018

attempts to control who attended a memorial service, and to seek to limit attendance to those they felt had been friends of the deceased.[284] In doing so, they were constructing the deceased prisoner as part of a particular social group. There could also be a reluctance to talk about the deceased in a more public setting. This could be for several reasons. When Eddie died, one of his closest friends was pleased to have been asked to speak by the chaplain leading the memorial, but felt unable to do so because he did not wish to show the emotions it would provoke.[285] Other prisoners saw it as inappropriate to be expected to speak or withheld their testimonials as a way of claiming kinship with the deceased:

> *But when they turn to us and as I say "has anyone got anything to say about him" and everyone just turned round and looked at us, I was just "Listen, my memories are my memories". And this lad at the front went "well, we want to know what he was like". "No you don't. You just want to stick your nose in. You didn't know him, you've just come down here. It's too late, the point is you didn't know him"*[286]

As before, certain crimes were more stigmatised, and the memorial service could make this more apparent, suggesting some prisoners regarded certain of their peers as 'ungrievable'. At HMP Leeds, chaplains were careful about the format of the memorial service, aware some prisoners may make derogatory remarks about prisoners who had been convicted of sexual offences.[287]

5.7 Conclusion

Dying was closely associated by many participants with ageing, and the ageing prison population, especially at HMP Wakefield, regarded as presaging more deaths from natural causes in the future. Understanding dying as linked to ageing changed attitudes towards some prisoners, including from their peers. It also changed the attitudes of some prisoners towards their own sentence, increasing an awareness when a death occurred that it would one day be them. Death was linked by participants to certain ailments, to the individual's physical appearance and as discussed in chapter four, to their location within prison custody.

Considering how an individual is constructed as a dying prisoner illuminates both what influences responses to terminally ill prisoners and how the culture and

[284] Fieldnotes, Wakefield, 9/2/2018,12/6/2018
[285] Fieldnote, Wakefield,12/4/2018
[286] Interview 14, Wakefield
[287] Interview 8, Leeds

relationships within a prison are affected by deaths from natural causes. Dying prisoners were awarded different dominant statuses by prison staff, typically 'prisoner' or 'patient', but sometimes 'person'. These constructions of the dying prisoner were shaped by differing occupational cultures and staff roles in the prison. Healthcare staff in particular experienced a tension between whether these men were 'patients', their preferred construction, or 'prisoners', the perceived construction of prison officers. Not all staff experienced this in the same way, but these constructions were relevant because of the way they affected care, discussed in the next chapter.

The different constructions of the dying prisoner's dominant status were intrinsically linked to the value placed on them as an individual, but also to the relationship between them and the staff member doing the figuring. Prison officers, focussed traditionally on discipline, were more likely to see the 'prisoner', healthcare professionals, with a focus on care, the 'patient'. Arguably it was the chaplain's role in providing pastoral care that led to them constructing the individual as a 'person'. As has been seen, attitudes towards a prisoner could soften in light of a terminal diagnosis or the approaching end of life. The humanity of prisoners often became more apparent to staff when they were aware the individual had a terminal diagnosis, but this was not universal.

Nurses, professionally used to building emotionally close relationships to facilitate medical outcomes (Savage, 1999), could find their approaches challenged when surrounded by prison officers with a different occupational culture. For the nurses, constructing the dying individual as a 'patient' led to encouraging them to ask for help, and using physical touch, including hand holding, in ways they felt officers disapproved of. For prison officers, more typically constructing the same individuals as 'prisoners', the dying prisoner's dominant status meant their responses to the situation were predicated on maintaining security and discipline and managing risks. Each of these constructions brought its own consequences for the treatment of the dying prisoner, with displays of compassion being more closely associated with the 'patient' status, and security considerations being foregrounded when the individual was regarded as a 'prisoner', stigmatized and posing a risk needing managing.

The typical approach taken by prison officers to the dominant status of the individual as 'prisoner' regardless of a terminal diagnosis was also the one reflected in the prison rules. It was also this approach that led to deceased prisoners being regarded as 'not grievable', especially by prison officers. It permitted a lingering

stigmatisation (often visible) of dying prisoners and maintained the loss of autonomy associated with imprisonment, which at the end of life was potentially experienced as less than optimal care. The priorities of the prison rules are security and bureaucracy. When these are related to the circumstances around the end of life, they become the prevention of prisoners escaping or harming people, the imperative of keeping records, and of producing the documentation that after a death will be essential for the inevitable investigation.

However, staff, including prison officers, did feel sympathy for dying prisoners that amended their construction of these individuals, softening their approaches and making it more possible to see the humanity of the prisoner, to construct them as a 'person'. Several factors influenced how much sympathy was felt towards a dying prisoner. These included their age, the nature of their offence, behaviour towards staff whilst in prison and their attitude towards their illness. In many cases, building a relationship with the prisoner's family served to increase sympathy for the prisoner, constructing another identity for them as part of a 'normal' family. The most significant factor in how much sympathy a prisoner was afforded was the nature of their offence. Officers in particular were aware they were expected to feel sympathy towards dying prisoners, but struggled to do so when the individual's crimes were of a sexual nature or against children. In this respect, they were arguably influenced by the attitudes of the broader society. Sympathy mattered because it affected constructions of the dying prisoner and informed adjustments to the prison regime (the usual running of the prison) that influenced the provision of care, as discussed in the next chapter.

Even though sympathy could be extended to some dying prisoners, the fact of their imprisonment remained a strong determinant of their experience of dying. The deprivation of autonomy associated with being a prisoner (Sykes, 1958) continued after a terminal diagnosis, limiting the autonomy and agency available to a prisoner at the end of life. Eddie's case illustrates the importance of a prisoner being liked, having a record of not being problematic to staff and having friends willing to care for him if he is to have his wishes respected. However, the deprivation of autonomy could continue after death, with some prisoners not being able to have the reassurance of their body being disposed of as they wished because of the requirement to bury it in case a next of kin later made themselves known.

The 'grievability' or otherwise of a deceased prisoner was indicative of how they had been figured by others during their life. Prisoners watched staff responses to a

prisoner's death, particularly those of officers, to gauge how much value they placed on the living prisoners. Some staff did mourn prisoners who had died, especially when they had known the prisoner for many years. For healthcare staff, it was an occupational norm to feel and show some grief at a death. Prisoners also said they had felt grief after a prisoner they had known had died. They appreciated informal opportunities to grieve the deceased, but expected the prison to also provide formal memorial services. For them, aware as they were of the different ways in which staff constructed them, as 'prisoner' or perhaps 'patient' and very occasionally 'person', what mattered was a dying prisoners being seen as a human being.

Chapter 6: Constructing quality end of life care

6.1 Introduction

The World Health Organisation (2019a) defines palliative care as:

> *An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.*

Good quality care for people who are dying therefore needs to integrate psychological, social and spiritual aspects, alongside the medical management of symptoms, and include their families. This chapter explores understandings and forms of care towards the dying prisoner and describes how prison personnel construct quality care. Delivering quality end of life care in the prisons studied did not rely solely on the medical expertise of the healthcare team. Nurses, prison officers, chaplains, governors and others, including prisoner-carers and family liaison officers, all potentially had a role in meeting the holistic needs of a dying prisoner. Their understandings of care were essential in determining responses to the dying prisoner and influenced the extent to which deaths from natural causes impacted on the prison regime.

This chapter considers the caring culture and caring relationships within the prison. It will apply typologies of care (Fisher and Tronto, 1990 and Kohn and McKechnie, 1999) to the caring actions observed during the fieldwork in order to illuminate the breadth of how care was conceptualised and performed. Focussing on relationships between prisoners, the importance of the role of the prisoner-carer in meeting the dying prisoner’s social and psychological needs becomes apparent. It is argued the care found in the community of prisoners can positively impact the experience of dying. However, because of bullying and victimisation of the frail, the community around the dying prisoner may also have a negative impact.

Next, the discourses shaping constructions of end of life care in prison, in particular the desire to find perceived standards against which to evaluate care, are considered. These standards will be seen to be loosely defined, unsystematic, subjective and often highly personal. There were three main discourses by which staff and prisoners evaluated the care of the dying. It will be shown that for many staff, constructing good end of life care was heavily influenced by the principle of

equivalence, the idea that prisoners should receive the same standard of medical care as someone in the community. There was no means for measuring this and the strongly held and divergent views between staff and prisoners as to the extent to which this was achieved are discussed in detail below. An alternative evaluation of care is provided by a more nebulous sense of what makes for a good death, amended to recognise the limitations of the prison setting and summarised by one participant as aimed at making death 'as good as it could be'. The importance of personal values and experience, particularly understandings of 'decency', will be explored in relation to this objective. A third way of evaluating care is provided by the expectation of an investigation after a death, something not experienced in all deaths in the community but resulting from the prisoner's status of dying in state custody. In this context, care will be seen to be defined as meeting the standard the Prison and Probation Ombudsman (PPO) investigation will deem satisfactory, a standard that cannot be confirmed until after a death has occurred.

Following this, it is important to consider the practical impacts on care resulting from the dying prisoner's incarceration and the extent to which these could be ameliorated. The implications of security considerations on the delivery of palliative care are discussed, together with the mechanisms by which adjustments were made to meet the needs of dying prisoners within the demands of prison regime. The use of discretion and the role of authority are of significance and it will be suggested 'rule-failure' discretion (Schneider, 1992) is prominent because of the lack of rules, regulations or guidance to inform the broader palliative care of dying prisoners. Lastly in this section, the challenges of providing care respecting the medical confidentiality of prisoners are considered, in particular regarding any wish for resuscitation not to be attempted.

The chapter will end by considering caring for the people affected by a death, particularly a prisoner's family and the staff and other prisoners involved in their death. It will be argued that caring for the family has become a new task of the prison, reflecting WHO definitions which include care for the family in the aims of palliative care. As with the care of the dying prisoner himself, there are various measures of how the quality of the care for his family can be evaluated. With regard to providing, receiving or not receiving support, it will be shown that there are considerable similarities between the experiences and expectations of prison staff and prisoners. Care after a death matters but is not easy to deliver appropriately.

6.2 Caring in prison

The caring culture

Prisons could be assumed to be places where care is absent. However, in both prisons studied, there were many examples of care attempting to meet the needs of seriously and terminally ill prisoners. This care was apparent with regard to other prisoners too. Arnold (2016), discussing how prison officers understand their 'duty of care' suggests officers interpret this as needing to care for prisoners, not care *about* them. However, in the prisons studied, the care shown by some officers extended beyond this. Fisher and Tronto (1990) suggest care in its broadest meaning has four components: caring about, taking care of, care giving and care receiving, and all were observed in the prisons studied. In the prisons studied, care could be seen in small actions, such as an officer taking a few moments to quietly watch a prisoner walk away from him, a look of tenderness on his face as he tried to assess how the prisoner was doing that day.[288] It was apparent in a nurse carefully checking the temperature of a drink she was taking to a prisoner no longer able to feed himself.[289] It was present when a chaplain spontaneously placed his hands under a prisoner's armpit, talking him through the manoeuvre from wheelchair to armchair to improve his comfort[290] or when one of his colleagues made a point of spending more time with someone who had just received a terminal diagnosis.[291] Care was evident in another chaplain's account of helping a prisoner prepare for death.[292] It was shown on a regular basis by one of the prisoners helping Eddie, where the tenderness of the activity described below is redolent with care and respect, supporting psychological as well as physical needs.

> *He goes back into Eddie's cell and comes out with a pillow, in a prison-issue green pillowslip, which he sets squarely on the wheelchair. Then he's back into Eddie's cell, for longer this time. When he comes out, he's walking backwards, slowly, helping Eddie out and down the step. He's holding Eddie's left hand with his left hand and has his right hand under Eddie's bent left arm. It's done with care, but strength. Once Eddie is lowered into the wheelchair, they set off. …On their return, he helps Eddie out of the wheelchair. He stands behind him as Eddie climbs up the step back into the cell, his hand on Eddie's*

[288] Fieldnote, Wakefield, 7/12/2018
[289] Fieldnote, Wakefield, 23/10/2017
[290] Interview 5, Wakefield
[291] Interview 8, Leeds
[292] Interview 5, Wakefield

left side, guiding him in, poised in case he falls back. Again, it's done with gentleness and calmly, but with assurance.[293]

Discourses and examples of providing care occurred throughout the fieldwork. Care permeated the prison culture, especially at HMP Wakefield, to an unexpected extent. Care was a source of pride for those who cared about, took care of, or gave care. Officers on Eddie's wing were proud of comments from the nurses that he was doing better than expected because of the care he was getting there.[294] The concerns expressed by the officers on Eddie's wing suggested a more holistic view of palliative care than some of the healthcare team held. They were anxious to keep him on the wing so he didn't feel isolated and because that would ensure contact with his friends.[295] There were several ongoing conversations where officers checked with each other, and the researcher, what they understood to be the course of action most likely to meet his needs.[296] There were also accounts by officers in both prisons about providing care that were more akin to the 'war stories' Crawley (2004) heard. In contrast to the domestic nature of the everyday tasks she observed, the officers in Crawley's study told her tales about grappling with violent prisoners and dealing with riots. In this study, there were officers who spoke about providing care in circumstances where lesser men (and they were men) would have failed. They spoke of following orders to attempt resuscitation when rigor mortis had already started,[297] sitting with a prisoner in such pain he was shouting at God to let him die,[298] helping nurses clean a body where the skin had become translucent and bodily fluids leaked out of the corpse.[299] Giving care could thus be a performance of machismo, but it was also redolent of tenderness and compassion.

Kohn and McKechnie (1999) suggest care can be conceptualised in a variety of ways: as a duty, as a responsibility, a professional task or as a labour of love. Examples of each of these motivations in terms of the care of the dying were present in both prisons. Prisoners often regarded staff as having a duty to care, to the extent they expressed anger if this duty was not met and relief when it was. One striking example of this occurred when a prisoner collapsed. Officers attempted resuscitation and a prisoner, reporting on this to me, said the paramedics had told the officers they had done the right thing. The prisoner shared this assessment; they

[293] Fieldnote, Wakefield, 1/2/2018
[294] Fieldnote, Wakefield, 30/11/2018
[295] Fieldnote, Wakefield, 2/2/2018
[296] Fieldnotes, Wakefield, 1/2/2018, 13/6/2018
[297] Fieldnote, Wakefield, 30/11/2018
[298] Interview 2, Leeds
[299] Interview 6, Wakefield

had done their duty.[300] Officers, nurses, chaplains, governors and prisoners' friends all expressed a sense of responsibility to care. For nurses in particular, it was part of their professional identity. For prison officers, care could be a professional task, part of a security-driven imperative, the professional commitment to 'know your prisoners', adapted to knowing when care might be needed:

> *It's like the lad, the lad we've got here now, er he went out for chemotherapy yesterday, and he's always poorly two days after because the hospital want to keep him in but he won't stay in. So he has his chemo, he comes back. So the trigger with him is two days after he's had his chemo, so we know to keep an eye on him.*[301]

Officers who regularly worked with the same prisoners could notice small changes in their behaviour indicating something was wrong, and which led to them contacting nursing staff. But care could also be a labour of love between prisoners. Those caring for Eddie said they were "doing it for him"[302] and 'it's not an obligation, it's a devotion'.[303]

The community around the dying: caring relationships?

Whilst in prison, the prisoner has very little say over who is near him. Sykes (1958) suggests one of the pains of imprisonment is the deprivation of security arising from being forced to associate with men with violent and aggressive pasts who cannot be expected to abide by the rules of society. However, it was clear in both prisons that prisoners who were terminally ill could also expect to be in a community of prisoners who in Fisher and Tronto's (1990) terms cared about them and took care of them. Friendships did develop which supported seriously and terminally ill prisoners. In the close-knit community of H3 in HMP Leeds, a healthcare professional reported that when Iain had been admitted to hospital, she had found two of the prisoners "sat crying in their rooms".[304] These prisoners had got everyone to sign one of his T-shirts, which Iain kept as an indication of their esteem for him:

> *It's his most prized possession now. He actually has it up in the wall of his room. He loves it. And he said when he got it, it was such a pick me up because he was like "they all care about me".* [305]

[300] Fieldnote, Wakefield, 20/3/2018
[301] Interview 3, Leeds
[302] Fieldnote, Wakefield, 28/11/2017
[303] Fieldnote, Wakefield, 29/11/2017
[304] Interview 10, Leeds
[305] Interview 10, Leeds

Likewise, in HMP Wakefield, the healthcare centre formed a small unit in which prisoners got to know each other well. As one officer said:

> *They all eat their dinner at the same table. You don't have that on wings. So they get like a tight little unit. And when people are old and frail on there, you'll find the other guys will look after them, y'know. They'll fill their flasks up for them, they'll push their chair for them. So it's sad for them because they obviously realise that he's very ill.*[306]

Crewe et al. (2013) suggest that although prisoners often dispute their relationships with other prisoners are substantial, in their daily practices they were quite intimate. The examples they give from their research are domestic in nature, including waking each other up with cups of tea. Similar practices were found in HMP Wakefield. In general though, prisoners made a distinction between 'prison acquaintances' of which there were many, and 'prison friends', of which there were very few.[307]

Crewe at al. (2013) also reported the prisoners they interviewed found it difficult to not be able to show their 'caring side' whilst in prison. It was noticeable in HMP Wakefield how much prisoners employed as carers for their peers appreciated being able to express care. Those caring for Eddie were enacting a labour of love, as discussed previously.[308] This echoes the motivations found in studies of prisoners working as hospice volunteers in US prisons (Loeb et al., 2013; Cloyes et al., 2013). How effective prisoners could be as carers for their peers was sometimes doubted. One prisoner felt there was not much Eddie's friends could do for him, suggesting their care was limited to fetching him water and clean bedding. Similarly, Moll (2012) who studied five prisons, including HMP Wakefield, concluded that peer support for frail prisoners was limited to pushing wheelchairs, cleaning cells and collecting meals and laundry. Whilst this accurately describes the tasks undertaken by some prisoner-carers,[309] in practice Eddie's friends and carers did much more. Two prisoners in particular were observed checking with officers when to take Eddie for his medication, helping him into his wheelchair and pushing him across to the medicine hatch.[310] Officers knew they and others were cooking for Eddie.[311] His main carer gave officers a daily report on him, raising any issues, and especially

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[306] Interview 15, Wakefield
[307] Fieldnote, Wakefield, 7/11/2017
[308] Fieldnotes, Wakefield, 28/11/2017, 29/11/2017
[309] Interview 14, Wakefield
[310] Fieldnote, Wakefield, 5/12/2017
[311] Fieldnote, Wakefield, 18/12/2017

reporting on how he was eating.[312] This carer outlined a daily routine based on taking Eddie for his medication, getting him drinks and helping with his meals. Each day started at morning unlock by checking Eddie was awake and getting him a drink. Once he knew Eddie was alright, he went back up to the other landings to let his friends know.[313] This was in order to reassure them Eddie had made it through another night. Caring for Eddie therefore extended to his friends caring for each other. One of them, conscious of the burden carried by Eddie's main carer tried to take care of him. A fieldnote records he: "says he watches the football with B, takes some time out and has a laugh".[314]

Prisoners employed as carers were not permitted to provide intimate care and could not assist with washing, dressing or undressing areas of the body "usually closed for privacy and dignity".[315] In practice, the distinction between appropriate and inappropriate care became blurred. Eddie's main carer reported helping him into the shower, taking the cubicle opposite him for himself, but then helping him dry himself. He was quick to assert there was nothing untoward going on. He told me on three occasions about helping Eddie shower, but when an officer was nearby, the account was adjusted to not mention drying Eddie.[316] He was also concerned about how Eddie felt about this, fearing he was ashamed to need the help, but stressing he should not be. The approach of the prisoners caring for Eddie aimed to meet his physical needs but was very much informed by a concern for his psychological wellbeing. They knew Eddie liked to be on his own and worked to maintain his independence as far as possible, knowing Eddie valued it.[317] Eddie thus found himself in a community prepared to help (one of the six *Ambitions for Palliative and End of Life Care,* discussed later*)* which was instinctively trying to address the physical and psychosocial needs prioritised by the WHO definition of palliative care.

However, not all the community surrounding the dying prisoner was caring. The deprivation of security Sykes (1958) associates with imprisonment was also present in both prisons studied with regard to seriously and terminally ill prisoners. Dawes (2009), writing about ageing in prison, suggests some elderly prisoners were fearful of younger ones and avoided participation in activities in order to prevent victimisation. Accordingly, staff in H3 in HMP Leeds worried the older men

[312] Fieldnote, Wakefield, 14/11/2017
[313] Fieldnote, Wakefield, 28/11/2017
[314] Fieldnote, Wakefield, 7/11/2017
[315] PSI 17/2015, Annex A
[316] Fieldnotes, Wakefield, 28/11/2017, 7/11/2017, 30/11/2017
[317] Fieldnote, Wakefield, 5/12/2017

accommodated on the wing with physical and age-related infirmities needed protection from the younger, mentally unwell prisoners also placed there:

> *You've got vulnerable, very vulnerable prisoners up here. Old, on historic charges, you know from 70s and what have you, which means they are old men now, in their 70s, some in their 80s, wheelchair bound, very vulnerable, to unpredictable prisoners, which some of these are, under the mental health. And that's been my argument; you can't mix 'em.*[318]

In responding to the behaviour of more disruptive prisoners, staff often had to think first of the needs of the more vulnerable prisoners in their care, including the dying. When a disgruntled prisoner at HMP Wakefield protested by flooding his cell, staff were concerned if this was affecting Eddie, whose cell was two landings below. Whilst both prisons had anti-bullying activities, bullying was reported and prisoners recognised that terminally ill prisoners on the wing were vulnerable.[319] This is in keeping with a point made by Lillie (2018): the bodily losses such as the loss of mobility, continence and cognitive function experienced by prisoners at the end of life make them vulnerable. Staff in HMP Leeds, where Dean had asked to stay on the wing with his friends, reported that the same 'friends' stole from him, targeting his medication.[320] One prisoner in HMP Wakefield gave as an example someone having been bullied for their morphine patch and commented on the lack of morality in such an action saying, "if they can do that, bullies can do anything".[321] Another prisoner, expecting to die in prison, said he saw younger prisoners bullying older ones, and worried how he would cope in 20 years' time.[322]

Staff as well as prisoners were aware some prisoners would behave disrespectfully towards the dying. The concept of decency, discussed below, was important so it is not surprising that officers and others worked hard to try to maintain standards of decency around terminally or seriously ill prisoners, protecting them from the curiosity of their neighbours. One officer said:

> *I don't think they should be a side show. Do you know what I mean? Because, <u>they are</u>. We've had it before where people have never spoke to this guy*

[318] Interview 3, Leeds
[319] Fieldnote, Wakefield, 7/11/2017
[320] Interview 10, Leeds
[321] Fieldnote, Wakefield, 7/11/2017
[322] Fieldnote, Wakefield, 11/10/2017

before in their life and just go for, a look. So no, it's not a peep show, it's not a side show. The lad's dying, he needs his privacy.[323]

Similarly, the prisoners working as part of Co-Mission-D Arts to enhance the palliative care suite at HMP Wakefield emphasised the importance of providing a screen to shield the dying prisoner and his family from prying eyes.[324] They felt that privacy was lacking on the wing and they wanted to restore it at the end of life.

The community around the dying prisoner could thus be positively affected by his circumstances, developing and enacting relationships based on care. The circumstances of a dying prisoner could also negatively impact on their relationships with their peers, making them vulnerable to bullying, depriving them of respect and thus adversely affecting their psychosocial wellbeing.

6.3 Evaluating care

As Kohn and McKechnie (1999) point out, understandings of care are socially constructed. It follows that what is understood as good or bad care, or the right or wrong way to deliver care can be specific to a particular group or setting. In the prisons studied, the most common rationale for the construction of quality care was that of 'equivalence' and the focus was on medical and social care: is the medical or social care a prisoner receives equivalent to that received by members of the community not in prison? This applied to all health-related care, not just palliative care. There were however other ways of evaluating care used by staff in constructing their understandings, including those informed by personal values and personal experience, or by the expectation of an investigation which would hold to account those who had worked with the dying prisoner.

The ideal of 'equivalence'

The ideal of 'equivalence' was one many participants, both prisoners and staff, regarded as important in assessing the quality of care in prisons. It originates from UN and WHO instructions (World Health Organisation, 2019b). Charles and Draper (2011) summarise the importance of this ideal, saying:

the principle of equivalence assumes that, when it comes to responding to health-related needs, prisoners are equal in the morally relevant sense to those outside of prison and the fact of their imprisonment is not itself a morally

[323] Interview 3, Leeds
[324] Fieldnote, Wakefield, 10/1/2018

> *relevant difference sufficiently to justify unequal treatment where unequal means disadvantageous. (p.215)*

There should, according to this ideal, be no difference between the medical care available 'inside' and 'outside' the prison. The ideal of equivalence is not without controversy. Charles and Draper (2011) question the focus within the UK on equivalence of process, suggesting equivalence of outcome would be a preferable measure. Lillie (2018) goes further, suggesting that although there are examples of good practice in end of life care in prisons, and favourable reports from the PPO:

> *Nevertheless, there is no evidence that there is systematic equivalence in care provision, and there remain significant structural barriers to ensuring high-quality palliative care in prisons. (p.49)*

Regardless of such criticism, the importance of the idea of equivalence of process in the provision of general medical care is embodied in the rules and regulations governing prisons. For example, PSO 3050 makes it clear that within a week of arriving in a prison, a prisoner should receive a primary care assessment equivalent to that given when registering with a new general practitioner in the community.[325] Similarly, PSI 03/2016 seeks to provide social care equivalent to that available in the community, with the intention of ensuring local authority services can operate within the prison:

> *so that prisoners who may have needs as a result of illness, disability or age… have equivalent access to care and support services as in the community, and are supported to live with dignity and as much independence as possible.*[326]

In both prisons studied, participants' assessments of the quality of care provided or received relied heavily on the ideal of equivalence as the standard by which care could be evaluated, although its application was very subjective and linked to personal experience. Several references were made to care being better or worse than could be expected in the outside community.[327] There was a clear divide between staff and prisoners in their assessments of how far equivalence was achieved. Some staff regarding the care in prison as better than equivalent and most prisoners as worse. Whilst staff and prisoners made their own assessments of whether or not a prisoner had received care equivalent to that received by members

[325] PSO 3050, 2.12
[326] PSI 03/2016, 1.8
[327] Interviews 5, 13, 11, Wakefield; 10 Leeds. Fieldnotes, Leeds, 1/2/2017; Wakefield, 21/11/2017, 7/11/2017, 20/10/2017

of the community not in prison, it was only after death this received external validation. The importance of the ideal of 'equivalence' is manifested in reports by the Prison and Probation Ombudsman following a death in prison custody, which explicitly specify whether or not the standard of care received by the deceased was equivalent to what he would have received in the community.

The *Dying Well in Custody* charter (Ambitions for Palliative and End of Life Care Partnership, 2018), was followed shortly after by a self-assessment tool for prison use. These publications followed nationwide discussions involving palliative care specialists and prison staff in various roles. Based on *Ambitions for Palliative and End of Life Care; a national framework for local action 2015–2020* which was developed by a partnership involving the NHS, medical organisations and the voluntary sector, it sought to achieve equivalence for palliative care into the prison setting and update existing guidance. It states six 'ambitions' for end of life and palliative care:

- *Each person is seen as an individual*
- *Each person gets fair access to care*
- *Maximising comfort and wellbeing*
- *Care is coordinated*
- *All staff are prepared to care*
- *Each community is prepared to help* (National Palliative and End of Life Care Partnership , 2015).

Whilst these 'ambitions' had been translated into the Dying Well in Custody Charter, they were not reflected in prison 'rules' and as such the standards of palliative care in the community were not yet formally embedded in the expectations of palliative care in the prison. This is perhaps inevitable given none of the relevant PSIs have been reviewed since the *Ambitions* document was produced in 2015. As a result, the matters of concern around a dying prisoner, as manifested in the rules and regulations governing responses, are very different from those of the *Ambitions* document on the care for a person dying in the community. Intended as a self-assessment tool, it is not mandatory for prisons to use the adaptions of the *Ambitions* document that constitute the *Dying Well in Custody Charter*. This had been trialled at HMP Wakefield but was not mentioned by healthcare staff there. Nursing staff at HMP Leeds were excited by the possibilities for improvement it offered, but aware it would be "a huge piece of work" to implement.[328]

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[328] Interview 10, Leeds

Constructing care as 'better' in prison

Staff in a variety of roles in both prisons presented the case for care in prisons, particularly at the end of life, actually being better than in the community. The main difference was seen as the availability of healthcare professionals within the prison, able to respond whenever needed. This was contrasted to someone dying at home, where carers might visit only a few times a day, rather than the level of care or frequency of checks provided to someone dying in a hospital or hospice. Staff made comparisons with their family members who had received end of life care at home or imagined how care would be provided at home in such circumstances. Reflecting on one death, a governor said:

> *Probably had more care and attention than some people would have outside. And I think I can say that for quite a lot of the men here. Y'know, for the care and attention that they get. Not everybody would get a doctor on call, not everybody would get a nurse that would deal with them, y'know if they were in their home circumstances they wouldn't have that care.*[329]

Similarly, the prospect of death outside custody was viewed as potentially more unpleasant and less dignified for prisoners who had committed offences which were especially stigmatised or who had lost contact with their family for other reasons. Speaking of Eddie, one officer tried to describe what he imagined would be the case:

> *if Eddie was in the community, he, it could be that he'd be left to… and he struggles with whether to say what he was going to say. Eventually he says, 'sit in his own shit', and then apologies to me for the language.*[330]

Nursing staff were aware that in the community, a district nurse would make a limited number of visits to a dying patient a day, and saw a fairer comparison as being between a hospice in the community and the palliative care suite in prison:

> *For someone in a palliative care suite in one of the prisons that's already got it well established, they've always got a nurse with them 24 hours a day, who is there on hand, like in a hospice, to do exactly what they need whenever they need it. Whereas in community, from a district nurse point of view, we'd go in three, four times a day.*[331]

[329] Interview 13, Wakefield
[330] Fieldnote, Wakefield, 1/2/2018
[331] Interview 10, Leeds

This nurse had tried to have the perceived higher standard of care in prison reflected in the post-incident reports following a death, challenging the clinical reviewer to report this, but said:

> *But when the report comes out, it'll just say that it was the same as they would have received, y'know, rather than better. And she sort of said "well we can't really put better because that would cause a riot". And it's like, "but if it is better, you should put it".*[332]

The concerns raised by the clinical reviewer that it would be unacceptable to the public for prisoners to be seen to receive better care than other people are interesting. Foucault says the public believe the "condemned man should suffer physically more than other men" (1991, p.16). This is clearly undermined by the UN and WHO ideal of equivalence of care for prisoners but lingers on in the reviewer's reluctance to report care as better. Wanting the care provided to be recognised as better was perhaps a mechanism for the emotional labour needed to find reassurance that everything had been done for someone dying in circumstances regard as far from optimal. For some staff, if the availability of professional healthcare support was better for the dying in prison, it was necessitated by the fact of imprisonment:

> *And I think you've got to treat them like that because they haven't always got somebody else around and they can't just pick up the phone and call somebody.*[333]

Care in prison had to be better, in the opinion of this participant, because the prisoner was restricted in so many other ways with regard to having their needs met.

Constructing care as 'worse'

Prisoners also used the ideal of equivalence to evaluate the standard of healthcare available in the prisons studied but reached very different conclusions. Prisoners were generally critical of the prison healthcare provider or of the medical and social care that was offered. This is in keeping with findings from Aday and Wahidin (2016) who say it is common for prisoners to mistrust medical care in what they see as a defective system, with well-documented delays and denials of treatment, and when they have seen prisoners suffering resultant pain and humiliation. One prisoner

[332] Interview 10, Leeds
[333] Interview 8, Wakefield

thought his peers would always regard the person who had died as not having received proper care and that "everyone will attack the staff, all staff, for people who pass away".[334]

Stories about poor general medical care circulated and had currency amongst prisoners, feeding a widespread perception that care was not equivalent to that available outside. In HMP Wakefield, the healthcare provider, Care UK, was referred to by prisoners as "Don't Care UK"[335] and described as worse than useless[336] and lacking compassion.[337] Specific examples of poor care were readily shared. The treatment of chronic conditions in particular was compared unfavourably to the care received before imprisonment. This is in keeping with Condon et al.'s (2007) study which found examples of prisoners who had entered prison with conditions such as diabetes, Crohn's disease and incontinence not being able to access the same food or medical equipment as they had relied on in the community. In HMP Wakefield, one prisoner spoke about having to walk the 200 yards to the healthcare centre in his pyjama trousers since no wheelchair was available on his return to the prison after seven weeks in hospital.[338] Another spoke of a prisoner complaining of chest pains not being seen in a timely manner.[339] In HMP Leeds, one prisoner said his monthly pacemaker checks before he came to prison had been replaced by one check-up in 10 months.[340] Another had written to his solicitor about problems getting regular medication when shortages of pharmacy staff had resulted in him receiving only two doses of a medication a day when he should have had four.[341] A prisoner at HMP Leeds reported having two different forms of cancer, but having missed a planned operation because the prison authorities had got him to the hospital too late.[342]

Both prisoners and some staff, including healthcare professionals, attributed problems with healthcare to a lack of training.[343] Some also added in a lack of

[334] Fieldnote, Wakefield, 14/11/2018
[335] Fieldnotes, Wakefield, 19/9/2017, 11/10/2017
[336] Fieldnote, Wakefield, 7/11/2017
[337] Fieldnote, Wakefield, 21/11/2017
[338] Fieldnote, Wakefield, 27/10/2017
[339] Fieldnote, Wakefield, 11/10/2017
[340] Fieldnote, Leeds, 19/2/2018
[341] Fieldnote, Leeds, 19/2/2018b
[342] Fieldnote, Leeds, 25/4/2018
[343] Interviews 11, Wakefield, 1, Leeds

equipment and a lack of ability, with one officer concluding that far from care being equivalent, “it’s unfair, it’s unfair”.[344]

Trying to make death “as good as it could be”

For staff and prisoners alike, an alternative means for evaluating care was summarised by one senior member of staff as making death “as good as it could be”.[345] This was based on assessments of what was desirable for prisoners at the end of life, but lacked clear or shared standards against which to form assessments. It was more nebulous than the ideal of equivalence but encompassed all aspects of the WHO definition of palliative care and was often informed by personal values or personal experiences of bereavement. Implicit in making death ‘as good as it could be’ was a recognition that dying in prison is far from ideal. It could be argued, as Lillie (2008) does, that a good death is not easy to achieve in any setting, and many staff and prisoners were aware of this, as evidenced in the discussion of how the care received by those dying in prison could be ‘better’ than in the community. However, most of the participants who were actively trying to make death ‘as good as it could be’ saw dying in prison as a deeply unattractive prospect, regardless of the care available or arguments that the standard of care was better than in the community. Setting an ambition of making a death ‘as good as it could be’ was often pragmatic but tinged with sadness. Ultimately, dying in prison was not a good ending. An exchange with an experienced senior officer sums this up:

> *Participant: I think that I’d try to do the best for anybody to make their last few days as, er, best possible for them.*
>
> *Interviewer: Right. And prison’s not that?*
>
> *Participant: Course it isn’t.*[346]

Studies regarding the provision of palliative care in prison often highlight the contradictions between the aims of palliative care and the purpose of imprisonment. Wrigley (2018) summarises this:

> *The goals, aims and means of providing good end-of-life care are precisely those that are difficult or impossible to secure in a prison environment. (p.22)*

[344] Interview 11, Wakefield
[345] Interview 13, Wakefield
[346] Interview 6, Wakefield

For Burles et al. (2016), prison regimes are at odds with the concept of a good death, which is characterised by comfort, control and closure. However, those staff and prisoners overtly trying to make death as 'good as it could be' were seen to be prioritising both psychological and physical needs. Providing comfort, control and closure were all part of their efforts. Chaplains also attended to the spiritual needs of the prisoners, and on occasions of their families too.[347] This led to a broader understanding of palliative care than the ideal of equivalence, which tended to focus on medical treatment.

Certain core human values underpinned understandings of what a death 'as good as it could be' would involve. In the prisons studied, the concept of decency in death was given great importance, even if it was rarely defined or definable. As one nurse said:

> *So for me it's about people dying with dignity, respect and comfortable. And if I've done that, then I'm happy. We all die, don't we? And it's all about dying the right way.*[348]

Decency involved meeting the individual's psychosocial needs and was very much shaped by culturally specific constructions. Decency was particularly important when it came to prisoners dying outside of the prison who could be subject to the use of restraints. Officers who had been on 'bedwatches' spoke about decency as the motivating force for removing restraints when a prisoner was close to death.[349] This was another example of how an approaching death could lead to a softening of the prison regime. Notions of decency played a significant part in decisions about the application of restraints and whilst senior managers were conscious of potential criticism from the PPO, they were aware of how inappropriate cuffing could look to the public:

> *So you've got the decency element, y'know. And your walk in to a hospital, local hospital, if he's in a yellow and green suit, an SO and three staff or SO and 2, and he's walking with two sticks and he's on an escort chain, I don't think that portrays us particularly well if I'm honest.*[350]

Whilst the prison setting changed how 'dying the right way' could be achieved, it also explained some of the importance placed on decency as death approached.

[347] Interview 5, Wakefield
[348] Interview 10, Leeds
[349] Interview 6, Wakefield
[350] Interview 13, Wakefield

Decency is a term which resonates with the prison service. 'Decent' prisons are one of the aims of HMPPS (HMPPS, 2017), treating people with "decency and respect" is one of the values expressed in the HMPPS annual review (2018, p.8). Ensuring decency was part of trying to make death 'as good as it could be' in prison. It was closely linked to dignity and privacy, a concept usually hard to find in prison but highly valued around death, for example in the provision of a screen in the palliative care suite[351] and the expectation that the body would be shielded from view.[352] For prison staff and prisoners alike a good death meant making the dying prisoner as comfortable as possible. Physical comfort, the tangible softening of an often harsh environment, was important, with the officers on Eddie's wing seeking to get a more comfortable mattress for him,[353] and concerned about noise near his cell.[354] It was also regarded as important to ensure someone died peacefully.[355] One of the significant concerns associated with dying in prison was the fear that someone would die alone. After Eddie's death, nursing staff felt upset he had been alone when he died.[356] Similarly, as mentioned in chapter five, a chaplain at HMP Leeds reported being saddened when he thought someone had died alone. At HMP Wakefield, a nurse reported:

> *I know L, one of our other nurses, she once sat with a gentleman all night, just so that he wasn't on his own. It don't go down well with officers, but you <u>have to</u>. Nobody wants to die alone.*[357]

The importance of ensuring the prisoner did not die alone was a strong enough motivation to overcome the practical difficulties and criticism from officers who did not share the same construction of quality care. Seale (1995) suggests when people die alone, it is regarded by others as indicative of their failure to provide emotional accompaniment. It is striking that it was nurses and a chaplain, people in occupational roles associated with caring, who felt the need for the dying to not be alone. Caswell and O'Connor, (2017) similarly find nurses working with the dying believe no one should die alone, although they also found that in their study, older people found the prospect of dying alone less problematic.

[351] Fieldnote, Wakefield, 10/1/2018
[352] Fieldnote, Wakefield, 10/1/2018
[353] Fieldnote, Wakefield, 1/2/2018
[354] Fieldnote, Wakefield, 30/11/2017
[355] Fieldnotes, Wakefield, 1/2/2018, 21/3/2018, 5/10/2017; Interview 10, Leeds
[356] Fieldnote, Wakefield, 9/2/2018
[357] Interview 12, Wakefield

In these regards, trying to make death 'as good as it could be' resulted in a broader understanding of palliative care than the ideal of equivalence, which tended to be interpreted in terms of medical care and treatment. Equivalence was however still part of understandings of making death 'as good as it could be'. Staff recognised the wing could become someone's 'home', and that when people in the community expressed a wish to die at home, for some prisoners the equivalent was being on the wing, in the surroundings that had become normal to them, and with their friends close by.[358] Ideas of equivalence were particularly noticeable in definitions of making death 'as good as it could be' when comparisons were made with specific individuals in the community which drew on personal experience of bereavement. For some staff, the goal was to provide for a dying prisoner the care they would like for their parent[359] and comparisons with the death of a loved one could be used to inform the desired standard of care for the dying prisoner.[360]

The expectation of investigation

Deaths in prison custody, even when anticipated, are always subject to investigation by the police, coroner and Prison and Probation Ombudsman (PPO). The findings of previous investigations after deaths from natural causes and the awareness of future investigations provided another means of evaluating the care provided to those approaching the end of life in prison. The expectation of an investigation also served to increase the importance of documenting and measuring care. When a death was anticipated, accurate record keeping became important because all records were likely to be included in the ensuing investigations.[361] Collating all of a prisoner's record and sending copies to the PPO, the Coroner and the prison service solicitor was in itself a huge task.[362] An awareness of the burden to be carried by accurate record keeping after a death was demonstrated by a governor who, on the day he was interviewed, had visited the hospital to review the use of restraints on a prisoner who was terminally ill. He said:

> *When I'm writing that up, I'm writing my sort of authoritative assessment of that risk, knowing that within 6 months that's probably going to be in front of*

[358] Interview 15, Wakefield
[359] Fieldnote, Wakefield, 13/6/2018
[360] Interviews 15 & 5, Wakefield
[361] Fieldnotes, Wakefield, 18/12/2017, Leeds, 26/6/2018; Interview 11, Leeds
[362] Interview 13, Wakefield

the PPO, or copies of that, and the coroner and everyone looking and assessing my decision. So my decision's got to be defensible, right?[363]

The *Dying Well in Custody Charter* was part of this agenda, with a nurse seeing it as a tool for evidencing the work done by healthcare staff for the investigation following a death.[364]

The expectation of an investigation shaped the care given to dying prisoners by encouraging staff to prioritise the issues they knew would be the focus of the investigators. Attempts to find a dying prisoner's next of kin could be informed by an awareness that the PPO would be critical of a lack of family contact.[365] In the case of Neil at HMP Wakefield, where a family member had been allowed to sit with a dying prisoner for the first time, there was a belief this would happen again because it would be positively received by the expected investigation: "we'll get relatives in again. It makes us look good".[366]

In part as a response to the expectation of an investigation staff and prisoners placed considerable emphasis on the need to have a care plan in place for a dying prisoner. This might result from a 'case conference' or 'multidisciplinary team meeting', but getting a plan in place was seen as important.[367] For healthcare staff, this included liaising with specialists outside the prison[368] and attending meetings at outside hospitals, if that was where the prisoner was being treated, to ensure continuity of care when they returned to the prison.[369] Other caring actions might be speeded up because of an awareness of a likely investigation. At HMP Wakefield, when Eddie needed handrails fitting on his cell, this was done by the Works department very quickly. When I commented on the speed, a senior officer said: "even Works aren't stupid, they know he's going to die and no one knows when".[370]

The clear implication was that there was a need to forestall the potential criticism to be expected if delays meant he died without the handrails having been fitted. Other issues became more fraught because of the investigation that would follow a death. These included uncertainties regarding prisoner requests for resuscitation not to be attempted should they collapse, discussed later in this chapter. There was a

[363] Interview 7, Wakefield
[364] Interview 10, Leeds
[365] Interview 13, Wakefield
[366] Interview 12, Wakefield
[367] Fieldnotes, Wakefield, 14/6/2018, 30/11/2017
[368] Interview 1, Leeds
[369] Interview 12, Wakefield
[370] Fieldnote, Wakefield, 19/12/2017

concern to provide clarity for officers, so they would not be put in a position where a subsequent inquiry might blame them for their actions.[371]

Anticipating an investigation could lead to unexpected actions in a prisoner's last few hours. One officer recounted having been an escort on a 'bedwatch' and encouraging nursing staff to remove the syringe driver that was no longer needed from the prisoner's room before he died, so police would not seize it as part of their investigation. He had previous experience of the police keeping a syringe driver, an expensive piece of equipment, for over a year after the prisoner's death and did not want the hospital to be inconvenienced in this way. [372]

The expectation of an investigation could also change the care given immediately after a death, in ways which staff found emotionally challenging. As mentioned in the previous chapter, one nurse found it difficult that the expectation of an investigation meant she was not to be permitted to wash the body or provide the final stages of care she was used to delivering in her previous work outside the prison. Similarly, Neil's wife was told she had to leave his bedside immediately after his death because the cell would be regarded as a crime scene.[373] However, at times, the concern about a future investigation was put aside in order to do what was regarded as the right thing, even if it wasn't the mandated behaviour. A nurse spoke of being helped by an officer to move a prisoner after his death. She knew he should be left where he was but was anxious to restore some dignity by moving him into bed from the commode where he had died. In this instance, the value placed on dignity overrode any scruples about complying with needs of an expected investigation. Another officer reported working with a nurse to straighten a body and place a white sheet over it:

> *And the police said 'Who's done this? Who's done that? Have you touched the body?' 'Yeah (laughs) 'yeah, it were me'. And we'd got last rites in as well.*[374]

Confident in his occupational identity and clear about what constituted 'decency', this officer was unconcerned by the expectation of an investigation.

[371] Fieldnote, Wakefield, 30/11/2017
[372] Interview 2, Leeds
[373] Interview 13, Wakefield
[374] Interview 2, Leeds

6.4 The practical limitations of care

The implications of security considerations

Whichever means of evaluating care was used by staff or prisoners, care was in practice frequently subject to the overarching security agenda inherent in prisons. Security considerations influenced the physical, psychosocial and spiritual care of prisoners in often unexpected ways and made some adjustments impossible. As Lillie (2018) suggests, "the propensity to focus on security can lead to unnecessary diminishment of dignity in dying" (p.49).

For example, of huge concern to staff in the prisons studied was the appropriate use of syringe drives to administer pain relief. This was a contested subject, another area where the cultures of prison officers and prison management teams could clash with that of healthcare staff. Syringe drivers were seen to present a risk because it was thought by some that they could be used to kill the prisoner.[375] At the very least, their use on the wing was considered to be too risky. In HMP Wakefield it was envisaged that when Eddie needed pain relief requiring administration via a syringe driver he would have to move to the healthcare centre.[376] In HMP Leeds, despite accommodating lower risk prisoners than HMP Wakefield, healthcare staff were prevented from using syringe drivers at all, even though other prisons did, and felt this resulted from fear of the unknown.[377] Similarly, they were not allowed to provide terminally ill prisoners with doses of Oramorph,[378] although they knew other prisons provided three doses in a locked cabinet in the prisoner's cell for them to use as needed.[379] The security agenda of the prison thus directly influenced how terminally ill prisoners were administered with pain relief.

The provision of equipment for the terminally ill prisoner was also affected by security concerns. When Eddie needed an air mattress, there was a concern how long it would take the Security department to approve it, but no question of it being allocated without their approval.[380] Similarly, the group redecorating the palliative care suite at HMP Wakefield had so internalised the expectations of the Security department that although they wanted a screen in place to protect the privacy of dying prisoners, they designed it so staff could see over it.[381] The impact of security

[375] Fieldnote, Wakefield, 30/11/2018
[376] Fieldnote, Wakefield, 30/11/2018
[377] Interview 10, Leeds
[378] An oral solution of Morphine Sulfate
[379] Interview 10, Leeds
[380] Fieldnote, Wakefield, 1/2/2018
[381] Fieldnote, Wakefield, 10/1/2018

considerations was also present in other situations. At HMP Wakefield, the quality of the spiritual care one of the chaplains could provide for Eddie was in their view impaired because they felt unable to enter Eddie's cell without approval from the Security department.[382] At HMP Leeds, taxis were used to transport prisoners and the officers escorting them to local hospitals. The taxi needed to enter the prison to pick up and drop off the group, but only taxi drivers with appropriate security clearances could do this. One officer recounted without criticism having waited five hours for a suitable driver to be available to return an elderly and frail prisoner to the prison after he was discharged by the hospital.

The use of restraints on prisoners receiving treatment in outside hospitals, discussed in chapter five with regard to constructing the individual as a stigmatised security risk, had a number of immediate practical effects on the provision of care. Firstly, the prisoner and prison officer had to stay within a few feet of each other. When the prisoner was in bed, this meant the officer was by the bedhead. This impeded medical confidentiality, as discussed below. Escort chains were also observed to limit movement for eating[383] and although not tight, to leave temporary marks on the prisoner's wrist where the weight of the cuff rested.[384] Prisoners spoke about the psychological effects of being restrained. One, from HMP Wakefield, was distressed about being handcuffed whilst unconscious. He was later restrained using an escort chain, including when going to the toilet or for a shower in a room with no windows and only one, shut, door. He spoke about another man on the ward, from HMP Leeds, who had no legs but was also restrained with an escort chain.[385] Another prisoner, who had been on an escort chain for seven weeks in hospital following a major operation described having a:

> *stent in his side, a catheter, and a feeding tube in his arm. He holds his left arm out to one side as he says this, and then holds his right arm out, saying he was cuffed. He indicates that he was pinned down by the equipment and the chain, 'couldn't move; literally crucified'.*[386]

Being restrained was experienced by prisoners as unnecessary and uncaring. It had a negative practical and psychological impact on seriously and terminally ill prisoners. Ironically, it only happened because the prisoner was seriously ill. In stark

[382] Fieldnote, Wakefield, 7/11/2017
[383] Fieldnote, Leeds, 10/7/2018a
[384] Fieldnote, Leeds, 10/7/2018b
[385] Fieldnote, Wakefield, 12/10/2017
[386] Fieldnote, Wakefield, 20/10/2017

contrast to the other ways in which tangible and intangible aspects of the prison experience potentially softened as death approached, if a prisoner needed medical treatment outside of the prison, they were likely to experience an intensification of the harshness of prison in the form of the use of restraints.

There were occasions, at HMP Leeds, not at the higher security HMP Wakefield, in which individual understandings of care overrode security concerns, even if the result was that staff would be reprimanded. For example, officers on one of the 'bedwatches' observed were reprimanded by a senior colleague for allowing the prisoner to be in his own clothes, not in hospital pyjamas as the PSI stated.[387] Another member of staff reported having had his 'wrist slapped' after phoning the wife of a prisoner who was in an outside hospital and thought not to have long to live. Both the staff member and his line manager thought he had done the right thing, and that security had been unnecessarily strict.[388] In these circumstances, staff were often placing notions of decency or care above the idea of security, using their own experiences to make decisions about the appropriate course of action. However, such incidences were rare and not simply about providing care. With regard to the prisoner in his own clothes, officers were also making a pragmatic decision. They knew the prisoner would not be out of the prison long and, given the short-staffing in the prison, judged it an ineffective use of resources to ask for an officer to collect the prisoner's day clothes.

Adjusting the regime

In order to achieve a standard of care perceived by staff to be acceptable, to make death 'as good as it could be', staff considered adjustments needed to be made to the prison regime. During the fieldwork, a number of changes which softened the usual prison regime, at least in the immediate vicinity of a terminally ill prisoner, were discussed by participants or observed. This was especially the case at HMP Wakefield, where arguably as a high security prison, the usual regime imposed more restrictions on prisoners than at HMP Leeds. The changes made were often small but were usually intended to improve the physical or psychosocial care of the dying prisoner. Some adjustments were possible at the discretion of the individual officer but at both prisons there was a reliance on the authority of the Governing

[387] Fieldnote, Leeds, 10/7/2018
[388] Fieldnote, Leeds, 16/2/2018

Governor to permit some of the changes regarded as necessary to improve palliative care.

In some instances, providing care meant changes were needed to staffing levels or to the tasks undertaken by staff. At HMP Wakefield, additional staff had to be on duty to facilitate cell doors being kept open overnight, such as when Neil's wife was permitted to stay with him when his death was imminent.[389] Similarly, when an FLO was spending time supporting the family of a prisoner who was close to death or who had died, another officer was needed to cover their usual tasks.[390] Prison officers helped out healthcare staff in informal ways. One recounted helping nurses in HMP Leeds turn a very large prisoner in bed, aware the nurses could not do it without his help. He also reported officers helping nurses get a prisoner to the bathroom, again recognising they were going beyond the expectations of their role but saying: "it becomes a situation where you don't like to see someone that is going to die, suffer".[391]

This reinforces the argument made in chapter five that an impending death results in officers sometimes feeling and expressing sympathy towards prisoners and shows the importance of such sympathy in generating a willingness to make adaptions and soften usual practices. Other officers were critical of their colleagues who didn't help in this way, especially when it came to refusing to push a wheelchair.[392] Sometimes officers were conscious this was not their job, but they did it because nobody else was available.[393] Healthcare staff made adjustments to their working practices too, with the presence of prisoners such as Eddie or Dean on the wing requiring them to visit areas outside of the healthcare centre more regularly.[394]

One of the daily routines of the prison was the unlocking and locking of cell doors. Officers were observed locking down a wing at lunchtime on several occasions. On Eddie's wing, the slick, almost balletic routine of this was sometimes interrupted by the officer at Eddie's door stopping, stepping into the room, and having a brief interaction with him.[395] This did not happen at any other cell door, and although it was not observed every time, it was part of a concerted effort to have more contact with Eddie, to check how he was throughout the day and respond to any needs that

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389 Interview 7, Wakefield
390 Interview 7, Wakefield
391 Interview 11, Wakefield
392 Fieldnote, Wakefield, 23/10/2017
393 Interview 11, Wakefield
394 Interview 12, Wakefield
395 Fieldnote, Wakefield, 9/1/2018, 20/11/2017, 1/2/2018

might arise.[396] This had been agreed at a case conference to discuss his care, with staff being required to record these checks had happened,[397] part of evidencing care for the expected investigation. It was another way in which the presence of a terminally ill man on the wing resulted in additional work for the prison officers.

There were also changes to the equipment, food or visits that prisoners received, aimed at providing them with more appropriate care but granting them something to which other prisoners were not entitled. Some of the adaptions made for Eddie have already been discussed in chapter four, including installing a doorbell near his bed. When he was first ill, the prisoner responsible for allocating bedding made sure he got an extra mattress, arranging this himself rather than discussing it with staff.[398] A few months later, as Eddie's condition deteriorated, handrails were fitted in his cell[399] and later the doctor was reported to be trying to get an air mattress for him.[400] Adjustments were also made to the meals served to Eddie, including the timing, which was incompatible with his medication:

> *He has to have his meds at five, and then can't eat at five [as with the regime], so they've sorted out for him to have eggs, and dried potato and soup, but with bits of chicken in it.[401]*

There were some concerns however that he wasn't getting good enough food, that the portions were too small, and that a man in Eddie's circumstances should have whatever food he wanted.[402] At HMP Leeds, this concern had led to officers sometimes cooking for prisoners themselves, recognising the prisoner may not then be able to eat much because of his frailty, but concerned to provide him with whatever food he wanted as part of providing palliative care.[403] Adjustments were also made to visiting arrangements, as discussed in chapter five, with family members being permitted to enter parts of the prison not usually accessible to them such as the healthcare centres. There were also small adaptions such as cell doors being left open, discussed in chapter four.

The adjustments were made because the prisoner was thought to be dying and because this provoked sympathy amongst officers. Rules were less enforceable

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[396] Interview 5, Wakefield; Fieldnote, Wakefield, 19/12/2017
[397] Fieldnote, Wakefield, 19/12/2017
[398] Fieldnote, Wakefield, 15/12/2017
[399] Fieldnote, Wakefield, 19/12/2017
[400] Fieldnote, Wakefield, 1/2/2018
[401] Fieldnote, Wakefield, 18/12/2017
[402] Fieldnote, Wakefield, 23/11/2017
[403] Interview 2, Leeds

around terminally ill prisoners because their impending death often made officers more aware of a prisoner's humanity. As one officer said:

> *They tend to get a bit more grace. Er, staff tend not to be so robust with them, there's a bit of lee-way. A bit of. Most staff are very black and white, no grey areas. But yet with someone who's terminally ill, you let grey areas slip in.*[404]

Another, aware the adjustments usually resulted in variations from normal practice, stated:

> *It becomes more of a human nature than an officer-prisoner and you maybe do things, not wrong, not, not legally wrong, but for support of the person who is going to pass away.*[405]

The danger in this use of discretion, based as it was on a sense of sympathy and notions of decency, was that it could become arbitrariness. One prisoner said about getting what was needed as an elderly prisoner or one in a wheelchair: "if you're lucky your face fits and you know which officers to ask".[406] Here the construction of individual prisoners became relevant. Those for whom staff were more able to feel sympathy were arguably more likely to experience the small adjustments to the regime that facilitated good palliative care.

For more significant adjustment and deviations from the 'rules', there was a reliance on the authority of the Governing Governor. As was discussed in chapter four, the Governing Governor had a key role in determining the location of a dying prisoner and thus could determine the extent to which the psychosocial needs of the prisoner were met. At HMP Wakefield, if he was content for Eddie to stay in the wing, even though this was not usual practice, senior officers would accept it. Staff in all roles placed considerable weight on following the rules and constructed some as requiring permission from someone higher in the hierarchy before they could be overturned. How much discretion they had depended on their own place in the hierarchy. An officer at HMP Wakefield spoke about always checking with the prison authorities before changing a prisoner's restraints at the request of a hospital consultant.[407] In contrast, a custodial manager at the same prison felt comfortable making that judgement himself, but still reported immediately to the duty governor to get

[404] Interview 9, Leeds
[405] Interview 11, Wakefield
[406] Fieldnote, Leeds, 2/5/2018
[407] Interview 11, Wakefield

agreement to the decision.[408] A governor at HMP Wakefield, who had worked with the then Governing Governor for a number of years, felt confident they knew what he would think about a subject, and so might act first, but would still contact him to explain what had been done and why.[409] In other cases, such as when Neil's wife had stayed with him overnight immediately prior to his death, when one senior member of staff had challenged another about what was planned, it was sufficient for her to respond: "I said it had all gone passed the Number One "Oh, it's going to happen then". "Yes, it is". In other words, wind your neck in and get on with it".[410] Likewise, at HMP Leeds, if there was insufficient staff available to facilitate a prisoner receiving a visit in H3 rather than the Visits hall, if the instruction had come from higher up in the hierarchy, it had to be done regardless.[411]

In the context of a more general prison population, Liebling and Maruna (2005) argue the rules, regulations and guidelines in place within the prison service require subjective interpretation. They find the use of staff discretion leads to inconsistencies and arbitrariness in how rules are implemented. In this research, for prison officers working with dying prisoners, there was a concern that the rules and guidelines in place did not cover the situation in which they found themselves. As previously discussed, the PSIs, PSO and Prison Rules did not directly address the likely needs of dying prisoners, relating to arguably tangential matters such as the arrangements for hospital escorts and the use of restraints. They did not embody the principles of palliative care many prison staff were instinctively trying to implement when a death was expected. One CM asked specifically about when I would give feedback to the prison from my research, hoping I could provide useful advice. He said that most of the time he and his colleagues were guessing what to do.[412] Schneider (1992) suggests 'rule-failure' discretion is prominent in prisons. This was often what was being observed in this study. In the very hierarchical and rules-based environment of the prison, where there is a 'never-ending flow' of regulations, discretion has become an intrinsic part of a prison officer's role (Liebling, Price and Shefer, 2011). In the context of dying prisoners, it is even more important because the gaps in the 'rules' left prison officers feeling they are guessing what to do.

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[408] Interview 6, Wakefield
[409] Interview 7, Wakefield
[410] Interview 13, Wakefield
[411] Interviews 9 & 16, Leeds
[412] Fieldnote, Wakefield, 13/6/2018

Ultimately, however, the need to keep the routines of the prison running, to maintain the prison regime, meant any adjustments were limited, noticeable to perhaps only a few people. As one officer said: "the wing will carry on as normal regardless of their ailments and regardless of their condition".[413] Practical changes might be made, informed by a use of discretion that was often hierarchical in nature, but the desire to provide what was perceived as quality end of life care would not significantly disrupt the prison regime.

Medical confidentiality and dealing with DNR

Medical confidentiality in prison was a contentious issue, but it was interesting that the tension was between the professional expectations of healthcare staff and those of prison officers, not between prisoners and staff. Condon et al. (2007) find a lack of privacy in accessing medical services was an issue for prisoners in all twelve prisons they studied, with prisoners feeling nurses were careless about medical confidentiality. This was not an issue raised by prisoners in this research project. Instead, prison officers working on the wings complained that despite having the most contact with terminally and seriously ill prisoners, they were not informed about their condition. Some saw this as adversely affecting their ability to care for the prisoner.[414] Nursing staff understood that officers might struggle to know what was needed:

> *Obviously as a nurse, information governance comes at the top of the tree and you don't disclose any confidential information to anybody that's not medical. But there's cert… you have to keep them in the loop about certain things that are going on because they are with them sometimes more than the nursing staff.*[415]

Nursing staff said there was a fine line between letting an officer know a prisoner was unwell and telling them too many details in a manner that would breach the expectations of medical confidentiality. For them, the important thing was ensuring officers knew there was a reason why the prisoner may need a nurse and would therefore fetch one in a timely manner.[416] The issue for both groups of staff was ensuring palliative care was coordinated, something included in the *Ambitions for*

[413] Interview 11, Wakefield
[414] Fieldnotes, Wakefield, 2/2/2018, 6/4/2018
[415] Interview 1, Leeds
[416] Interview 1, Leeds

Palliative and End of Life Care, and there was a strong sense amongst officers that practices related to medical confidentiality were a barrier to this.

The fact of imprisonment did significantly change the standard of medical confidentiality available for the prisoner. In part, this resulted from practical considerations. Hospital escorts were particularly difficult times to maintain medical confidentiality. Although medical information was not to be recorded in the Person Escort Record[417], confidentiality was often impossible to maintain and even officers could find the situation difficult, as one acknowledged:

> *They can't leave when medical information is being discussed and often hear things they don't want to. He says medical people are often not comfortable with this, and sometimes officers aren't.*[418]

One officer gave a very stark example of this:

> *You get in situations out on escorts, and daily escorts, hospital bedwatches and procedures that take place that are intrusive to the prisoner. You could be, erm, sat in a room with a person having an endoscopy and you're sat literally like that (mimes being close to something). And whichever way you look there are TV screens with their internal-what's-going-on. You can't get away from that situation.*[419]

Some officers reported that prisoners willingly shared medically confidential information with them.[420] One FLO spoke about checking with prisoners if it was alright to remain with them when nursing staff were present, and found prisoners usually felt it was useful for the FLO to know about their condition:

> *I'll just be saying to the prisoner, "Are you happy that I sit here and obviously I'm your FLO" and they are normally just fine with that, y'know. They know that obviously, they are not in a good way so there's no point really keeping it private. But I would ask them if they minded me sitting there.*[421]

This was indicative of the quality of relationship within the prison but perhaps also of the dependant nature of prisoners.

[417] PSI 33/2015, 6.4
[418] Fieldnote, Wakefield, 4/4/2018
[419] Interview 11, Wakefield
[420] Interviews 15, Wakefield; 3 Leeds
[421] Interview 15, Wakefield

Some of the challenges of providing quality care that respected the prisoner's wishes whilst maintaining appropriate medical confidentiality are highlighted by the difficulties presented by a prisoner's request for resuscitation not to be attempted. Dealing correctly with a 'Do Not Resuscitate' (DNR) request was a source of concern for staff, but also a way in which care was shown. Officers and healthcare staff demonstrated care by their commitment to respect a dying prisoner's wishes.[422] This was part of the value set informing the motivation to make dying in prison 'as good as it could be'. Dealing correctly with a DNR request was also a way of caring for colleagues, closely linked to the expectation of an investigation. There were concerns staff had been criticised by the coroner for not attempting resuscitation.[423] There were also stories about prisoners suing staff for having resuscitated them[424] and a belief that attempting resuscitation on a prisoner with a DNR request in place would be illegal.[425]

The importance of a DNR as a means of granting dying prisoners some autonomy was reflected in its inclusion in PSI 64/2011, where as part of a brief section on the "Management of prisoners who are terminally or seriously ill" it was stated:

> *Prisoners are able to be involved in the decisions made about the care they receive and in some cases make a decision not to be resuscitated.*[426]

PSI 64/2011 also states that:

> *It is key that information is recorded and that if a DNR is in place this information is shared with staff in order that the prisoner's wishes not to receive treatment are respected.*[427]

Senior officers in particular worried about how to communicate the existence of a DNR request to other officers whilst not breaking the expectations of medical confidentiality. The two prisons took very different approaches. In HMP Leeds there was an established practice of storing the DNR somewhere visible in the prisoner's cell, including when they were accommodated on a wing[428] and of taking a copy with the prisoner if he was taken to outside hospital.[429] Prisoner mostly accepted this,[430]

[422] Fieldnote, Wakefield, 30/11/2017
[423] Fieldnote, Wakefield, 30/11/2017
[424] Interviews 9, Leeds
[425] Interview 3, Leeds
[426] PSI 64/2011, Chapter 11
[427] PSI 64/2011, Chapter 11
[428] Fieldnote, Leeds, 1/5/2018; Interviews, Leeds, 21/2/2018, 1/5/2018
[429] Interview 9, Leeds
[430] Fieldnote, Leeds, 1/5/2018

although one did ask for it to be moved so he could not see it from his bed.[431] In H3, where terminally ill prisoners were most likely to be accommodated in HMP Leeds, the information would also be recorded on a white board in the staff office which listed each cell occupant, and was included in staff handovers between shifts. [432] There could still be problems with communicating this information. One officer at HMP Leeds reported a recent incident when a night nurse had spotted a prisoner with a DNR in place was having a heart attack and had started resuscitation.[433]

At HMP Wakefield, there was some confusion amongst prison officers and healthcare staff about what information could be or needed to be shared. Senior officers on Eddie's wing were concerned about how to ensure their junior colleagues knew he did not wish resuscitation to be attempted. They were also anxious to avoid colleagues facing criticism about their actions after his death. Nursing staff advised that the officers involved would have to have a copy of Eddie's signed request before not doing or stopping resuscitation.[434] This was kept in the Primary Care Centre in the centre of the prison, but inaccessible overnight. The senior officer had seen the original with Eddie present, talked it over with him, and then told his staff, but was concerned this was not legally sufficient. He thought it would be best to have a copy in Eddie's cell, but had been told by healthcare professionals this would breach rules on medical confidentiality and could be stolen or tampered with by other prisoners.[435] What was common practice at HMP Leeds in this regard was not considered possible at HMP Wakefield.

6.5 Caring for those affected

Caring for the family

The WHO definition of palliative care emphasises the importance of improving the quality of life of both the patient and their family. As discussed in chapter five, a terminal diagnosis for a prisoner or an unexpected death from natural causes led to a new form of relationship between prison staff and the prisoner's family. These relationships were based on prison staff caring about and taking care of prisoners' families, seeking to make a distressing time as easy for them as possible. Family liaison officers (FLOs) led on this, but prison chaplains also built relationships with

[431] Interview 2, Leeds
[432] Interview 2, Leeds
[433] Interview 2, Leeds
[434] Fieldnote, Wakefield, 14/11/2017
[435] Fieldnote, Wakefield, 30/11/2017

the families of dying prisoners, especially at HMP Leeds.[436] They and other staff talked about what they were doing for the family as 'support' rather than 'care'. For FLOs, the care offered included breaking the news appropriately, being a single point of contact within the prison for any questions, arranging or helping arrange funerals and significantly, shielding the family from media intrusion or further distress.

Much of the care provided was directed by PSI 64/2011. This states that prisoners with a terminal diagnosis must be encouraged to engage with their nominated next of kin and that the prison must have an appropriate member of staff to engage with this next of kin.[437] The caring role of this member of staff is apparent in the PSI, which emphasises their role in minimising the family's distress:

> *Where the prisoner is hospitalised, it may be helpful for the nominated member of staff to meet with the family to provide information, which may include discussing the escorting arrangements including whether the prisoner is handcuffed or not. This information will reduce the distress of the family and aid their understanding of prison escorting procedures.* [438]

The PSI also specifies the next of kin should be given accurate information, recognising that any failure to do this can increase their distress:

> *It is vital that accurate information about the prisoner's death is given to the next of kin. Inaccurate information given at this stage can cause unnecessary distress and suspicion and can undermine the prison's ability to build a relationship with the family.*[439]

It specifies the Governing Governor must write to the family to offer condolences and invite them to visit the prison if they wish, and contact them again after the draft PPO report into their relative's death has been agreed.[440] The Governing Governor is also tasked with offering to contribute to funeral expenses, and the PSI details what this can include, up to a maximum of £3,000. The care to be provided is therefore structured as a series of tasks. In the prisons studied, FLOs were performing these tasks by building relationships with the prisoner's family in which their support was offered organically, moving on to the next stage of the post-

[436] Interview 8, Leeds
[437] PSI 64/2011 Chapter 11
[438] PSI 64/2011 Chapter 11
[439] PSI 64/2011 Chapter 13
[440] PSI 64/2011 Chapter 12

mortem process as the prison and family required, but still with an awareness of the mandated tasks.[441]

The PSI specifies the role of the FLO starts when the family is informed of a death. In practice, in both prisons studied, when a death was anticipated the FLO made contact with families much sooner. In some cases, discussing a Do Not Resuscitate request was regarded as indicating an FLO was needed.[442] If a prisoner was approaching death, FLOs were often involved in supporting families at the bedside. Examples of this include the FLO who sat with Neil's wife overnight in HMP Wakefield, and the FLO from HMP Leeds who accompanied Iain's wife to sit with him whilst he was dying in hospital, both discussed above. Other staff did this too, including governors.[443] It was regarded as better for the family to be involved sooner rather than later, to prepare them for receiving the news and to start building a relationship.[444]

FLOs kept in regular contact with family members. The contact could continue for several months, up to and beyond the coroner's court and final report from the PPO into the death.[445] They spoke about this contact in terms of meeting the needs of the family member, of asking how they were feeling, rather than simply contacting them when there was question.[446] They tried to be responsive to the family's needs, asking them what they would like and were often aware the family member had no other sources of support.[447] Considerable sensitivity was needed from FLOs. They were aware when the conviction was for child abuse, the family members could experience shame, thinking staff would probably know what had happened to them.[448] FLOs were also aware it could be difficult for the family to have to explain who was or wasn't attending the funeral. FLOs recognised the importance of building up trust in these circumstances.[449]

FLOs and other staff within the prison often sought to protect the family as part of caring for them. They were aware that media interest in the prisoner's death could be particularly distressing, reopening the stigma the family had experienced at the

[441] Interviews 9 & 16, Leeds; 15, Wakefield
[442] Interview 16, Leeds
[443] Interview 7, Wakefield
[444] Interview 2, Leeds
[445] Interview 16, Leeds
[446] Interview 15, Wakefield
[447] Interview 16, Leeds
[448] Interview 15, Wakefield
[449] Interview 15, Wakefield

time of the conviction.[450] At funerals, governors attending from the prison knew sometimes not all of the mourners would have been told the deceased had been in prison at the time of the death, and they sought to shield the family by encouraging funeral directors to conceal this information.[451] Sometimes officers struggled with what to tell the family, because they feared the prisoner's behaviour, unrelated to their death, might add to the family's distress. One FLO spoke of responding to a death that was not from natural causes. The family asked for his watch. The FLO knew the prisoner had traded the watch for a mobile phone, found taped to his penis when he was taken to hospital, and knew this would upset them.[452] Other staff were conscious actions such as forwarding a prisoner's education certificates could cause distress, and sought advice about how to do this sensitively.[453]

Although their work arguably protected the prison from hostile criticism after a death, FLOs cared about the families they had supported. When interviewed, they often spoke at length about the families, regardless of the cause of the prisoner's death, remembering cases long past. For them, seemingly it mattered less how the prisoner had died, and more how the family was coping. They took pride in taking care of practical arrangements for the family, especially around the funeral. For FLOs, their managers and others involved in supporting prisoners' families, their understanding of quality care were based only in part on whether the tasks specified in PSI 64/2011 had been completed but relied more on the levels of satisfaction expressed by the family and the quality of the relationships developed. One chaplain recounted being able to chat with the wife of a terminally ill prisoner, who was very happy with the care he was receiving, and then after his death, meeting the extended family to plan the funeral held outside the prison. The care provided for the family could be evaluated as good because the prisoner's wife was content.[454]

Providing, receiving and not receiving support

In addition to prisoners' families, deaths from natural causes also affected both prison staff and prisoners. The deceased prisoner did not need to have been regarded as 'grievable' (discussed in chapter five) for a death to have an impact. Both staff and prisoners found deaths upsetting, sometimes stirring strong emotions, unconnected to any relationship with the individual who had died. This section will

[450] Interview 7, Wakefield
[451] Interview 13, Wakefield
[452] Interview 2, Leeds
[453] Interview 4, Wakefield
[454] Interview 8, Leeds

consider how care and support was enacted after a death to illuminate how such deaths impact on relationships in prison. How people were supported after a death reveals practices within the prison of care giving and care receiving (Fisher and Tronto, 1990).

Prisoners expected staff within the prison to support them when they needed care. This included prison officers and chaplains, and there was criticism of both when care was thought not to have been provided.[455] Chaplains in particular sought out prisoners they thought may be affected by a death. During Eddie's illness and after his death, chaplains made an effort to meet up with his main carer to check how he was feeling and raised any concerns with senior members of staff.[456] Prisoners expressed gratitude that chaplains were on a wing after Eddie's death, appreciating the care this suggested, even if they did not personally need the chaplain's pastoral support.[457] Staff could list formal sources of support for prisoners affected by a death, including the prison chaplaincy, the Listeners scheme and the Samaritans[458] but thought prisoners often preferred informal sources of support:

> *There'll always be somebody, unless it's that person who has passed away, there'll be somebody that they can go to.*[459]

Often, however, it was the perceived absence of support from staff that resulted in prisoners turning to fellow prisoners[460] with certain prisoners being regarded as particularly good at providing care.[461] Support could come in subtle ways, such as making sure other prisoners, employed as carers, had a break. In one meeting observed, where a prisoner struggled not to cry, another patted him firmly on the knee a couple of times to provide reassurance.[462]

What was harder for prisoners was finding people to talk to whom they trusted. Here the distinction between 'prison acquaintances' and 'prison friends' was relevant, as was the awareness that the people surrounding them were criminogenic. Prisoners were wary about which of their peers could be trusted not to break confidentiality. This could be a barrier to seeking informal support:

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[455] Fieldnote, Wakefield, 21/11/2017, 12/4/2018
[456] Interview 5, Wakefield; Fieldnote, Wakefield 14/11/2017
[457] Fieldnote, Wakefield, 9/2/2018
[458] Fieldnote, Wakefield, 7/2/2018, Interview 13, Wakefield
[459] Interview 13, Wakefield
[460] Fieldnotes, Wakefield, 14/11/2017, 18/4/2018
[461] Fieldnote, Wakefield, 14/11/2017
[462] Fieldnote, Wakefield, 23/3/2018

I'd talk to the inmates, but as soon as you start talking, there's a thing called trust. You talk to someone, they talk to someone else, they talk… And all of a sudden everybody knows your problems.[463]

Lillie (2018) suggests the lack of privacy and personal space in prisons make it harder to grieve the death of fellow prisoners. In HMP Wakefield, where cells were single occupancy, this was less of an issue. One prisoner there, talking about dealing with difficult feelings and the need to hide them behind a mask, said simply "happiness is door-shaped".[464] He welcomed being locked behind his door. There was no one he would turn to for support; only solitude would be effective.

For staff, formal support was also available from a variety of sources. In each prison this included a staff care team, a group of colleagues from different departments who volunteered to provide support. There was also an employee assistance programme for help with any work or personal issue which could be accessed by phone or online, as well as line managers, occupational health and staff associations such as the Prison Officers Association.[465] In HMP Leeds, the staff care team also provided support for healthcare professionals within the prison, who were employed by Care UK, because their provision was regarded as less than ideal since it relied on staff approaching their senior managers for support.[466] Chaplains regarded their role as including supporting officers and other staff[467] and healthcare staff expressed their appreciation of this.[468]

Despite the breadth of the formal provision, staff in both prisons often regarded it as inadequate. One officer suggested: "there's more care for prisoners from staff than there is for other staff".[469] There was criticism of some staff care team members at HMP Leeds as "nosy",[470] "deadwood" and "prone to gossip".[471] Some officers highlighted the lack of training in dealing with traumatic events[472] or perceived a lack of care in failures by senior staff to prepare them for potentially distressing experiences, such as being on a 'bedwatch' when a life support machine was turned off.[473] De-briefs could fail to include key people involved in the incident, and the staff

[463] Interview 14, Wakefield
[464] Fieldnote, Wakefield, 19/12/2017
[465] Interviews 7, Wakefield; 2 Leeds
[466] Fieldnote, Leeds, 20/2/2018
[467] Interview 5, Wakefield
[468] Fieldnote, Wakefield, 9/2/2018
[469] Fieldnote, Wakefield, 7/12/2017
[470] Interview 2, Leeds
[471] Fieldnote, Leeds, 20/2/2018
[472] Interview 11, Wakefield
[473] Fieldnote, Wakefield, 18/4/2018

care team could be slow to approach people.[474] Governors and members of the senior management team could be overlooked when staff were approached to identify support needs. Their role included prompting other staff to access the formal support available, but:

> *I think we sometimes forget the people who are overseeing it because they are looking after everyone else, and nobody is looking after us.*[475]

The formal support available was seen by several staff as failing most when it came to meeting the support needs of FLOs. At HMP Wakefield, one member of the senior management team had tried to address this by training as an FLO in order to understand the role and be better able to support them. Others felt more structured support was needed for FLOs, suggesting a regular meeting to 'offload', similar to the provision for officers working in the segregation unit with the most challenging prisoners.[476] At HMP Leeds, there was a concern that the FLOs did not have a coordinator to take responsibility for their support and workloads, and that this situation had been ongoing for a long time.[477]

In the absence or perceived failings of effective formal support, staff, like prisoners, sought out informal sources of support. Often this came from talking to one of their immediate colleagues. Chaplains and healthcare staff talked about finding support within their teams.[478] This preference for seeking support from colleagues rather than the staff care team is reported in other studies of prison staff after a death in custody (Ludlow et al., 2015). Officers were often more specific in where they sought informal support. Some took their concerns home. This is not unusual amongst prison officers. Crawley (2004) finds that although some prison officers preferred not to discuss work at home, others often confided in and sought advice from their partners. In two instances, officers who participated in the research felt they had an advantage with regard to getting support when working with a dying prisoner or after a death because they had wives with healthcare expertise. As one said:

> *I'm quite fortunate in the fact that when I go home I can talk to my wife and she listens. Because she used to work in a nursing home so she's seen plenty*

[474] Interview 16, Leeds
[475] Interview 7, Wakefield
[476] Interview 13, Wakefield
[477] Interview 9, Leeds
[478] Interviews 8, Leeds; 5 & 12 Wakefield

of dead people, she'd dealt with plenty of dead bodies and everything. So I get it out the system and then it's over and done with. I'm lucky.[479]

Other officers had one specific colleague they spoke to if they needed support. This could be a line manager, but it was also sometimes a colleague who had shared the experience. One participant spoke about going to the hospital in an ambulance with a prisoner who was declared dead when they arrived. Waiting for the mortician to return from lunch and then helping move the body and empty the prisoner's pockets had affected the other officer. He had not sought counselling but:

Years afterwards, we'd have a little chat and he'd bring it up, so I know that it did affect him.[480]

The subject remained something the affected officer needed support with, years after the event and seemingly only trusted the other officer involved. As with prisoners, trust was an important factor in who officers chose to seek support from. Another officer received support from a previous line manager, someone he had not worked with for many years and who had moved to a different prison because:

I can talk to her about things and it's not going to go any further. She can talk to me about things and it's not going to go any further. So really she's the only person I've ever really spoke to.[481]

What is striking is that there were similarities in where staff and prisoners sought support, and in their attitudes to the formal support provided. It is also noticeable that there were few differences in the care and support they sought around a death from natural causes compared to other circumstances where they might need help. The sources of support accessed and trusted remained largely the same.

6.6 Conclusion

Prisons have their own particular understandings of what constitutes quality care, including palliative care. The aims enshrined in the WHO definition of palliative care, and to a lesser extent in the *Ambitions for Palliative and End of Life Care,* were often part of this understanding, but in the prisons studied they were rarely referenced. Instead, many staff and prisoners were instinctively seeking to care about and take care of dying prisoners in ways that met their physical and psychosocial, and to a

[479] Interview 6, Wakefield
[480] Interview 6, Wakefield
[481] Interview 9, Leeds

lesser extent, spiritual needs. These efforts were informed by often very personal assessments about what constituted quality care, broadly based on three means of evaluating care, but used to provide some sort of standard against which to judge the care offered. Firstly, the ideal of equivalence was important to understandings of quality palliative care in both prisons and was a standard shared by both staff and prisoners. However, there was still scope for differing interpretations of what is equivalence and incidences where prisoners, and some staff, felt the care received has fallen short. A second, parallel understanding of quality palliative care in prison, of making it 'as good as it could be', served to highlight decency, a value treasured in other contexts within the prison service. Hard to define, closely linked to privacy, comfort, companionship and respect, it was nevertheless a value that prison service employees were familiar with, enshrined as it is in the service's value statements and the broader aims. Lastly, good standards of palliative care could also be defined in the context of an expected investigation. Whilst the demands of the coroner, PPO and prison service lawyers after a death presented a burden to staff in preparing the seemingly endless paperwork, the final reports gave some external evaluation of the care provided. Staff were aware of the aspects that would be important in the investigation, particularly the use of restraints, and whilst they did not always agree with the findings, or feel that the investigation recognised the care achieved, the awareness of an impending investigation did affect perceptions and delivery of quality care.

In contrast with other studies (Burles et al., 2016; Wood, 2007) which identify only difficulties arising from the prison regime for the provision of palliative care, the normal expectations of the prison regime, embodied in the prison 'rules' and in the standard practices within the prison, could both assist and hamper efforts to provide palliative care. PSIs requiring the appointment of family liaison officers served effectively to include prisoners' families in approaches to palliative care, as defined by the WHO. However, the security imperative, dominant in both prisons studied, could negatively affect palliative care, limiting options for receiving pain relief or requiring the use of restraints that affected both physical and psychosocial care.

Constructing quality palliative care as something that was regarded as important was linked to seeing the prisoner as someone deserving of sympathy because they were dying. It often led to a willingness to adjust the prison regime, to change normal practices and find space within the rules in ways which softened the usual experience of the harsh prison setting and subtly changed prison regimes. Some

adaptions, particularly those concerning the location of a prisoner or security considerations such as the removal of restraints, needed approval from senior managers or Governing Governors. However, many changes might be scarcely noticed by most people; the wing could keep running pretty much as before. These changes did not necessarily have a significant impact on the prison regime but they happened nevertheless, quietly adjusting normal practice by flexing timings, altering routines, deploying additional staff and providing additional goods to meet the needs of a dying prisoner. Deaths from natural causes thus generated new tasks, changed the normal practices of the prison and led the prison, via FLOs, into closer relationships with prisoners' families. Studies of prison officers (Liebling, 2016; Tait, 2011) suggest some officers have always cared for prisoners, but now they found themselves helping nurses provide physical care, pushing wheelchairs and negotiating for better food for a dying prisoner. The differences between the two prisons in how they dealt with DNR requests perhaps captures a moment where one prison was trying to catch up with new circumstances. At HMP Leeds, there was an accepted method for communicating DNR requests. At HMP Wakefield, the unusualness of accommodating on a wing a prisoner so close to death was presenting staff with challenges that at the time of the fieldwork still needed resolving.

The relatively small adaptions made were more significant in changing the culture of the prison. Discretion has always been part of how prison officers achieve their tasks but meeting the needs of dying prisoners pushed the use of discretion further. Prisoner culture softened too, with the circumstances of dying prisoners providing opportunities to display a caring nature, and to embody feelings towards fellow prisoners in practical actions. Relationships between prisoners became more intimate, as between Eddie and his main carer, because this was essential to providing good palliative care. There were limitations. The positive impact of the presence of a dying prisoner on the culture of the wing was not universal. Seriously and terminally ill prisoners were surrounded by criminogenic neighbours and for some the vulnerability associated with their bodily losses could make them prone to bullying from their peers.

Some aspects of prison regimes, culture and relationships were unchanged by the care of dying prisoners. Discretion was so important because there was 'rule-failure' (Schneider, 1992); the prison 'rules' had not been changed to reflect the new tasks of caring for dying prisoners. Medical confidentiality was often hard to maintain,

reflecting the low importance often placed on it because of the prisoner's status. And when care was extended to colleagues and peers, provided formally or informally, it used existing channels, treating the need for support around death and dying the same as any of the other problems staff and prisoners faced.

Chapter 7: Conclusion

Deaths from natural causes in prison in England and Wales are not new but have become more frequent. Prison staff and prisoners alike are faced with trying to adjust their thinking and adapt their practices, with little central guidance and with rules, all-important in the prison regime, which reflect a different set of concerns. The need of staff and prisoners to create a coherent understanding of the situation is behind the approach taken by this thesis. It has been shown how they are responding to what they regard as changing circumstances by constructing understandings of the carceral geography of death and dying, of the dying prisoner and of what constitutes quality care at the end of life.

This thesis argues that deaths from natural causes in prison custody can soften the usual distinctions between what is expected or not expected, permitted or not permitted, between 'inside' and 'outside' prison. The awareness a prisoner has a terminal diagnosis or is approaching the end of life in prison custody often leads to a blurring of the practical and emotional distinctions that have marked their lives as prisoners. Within limits, the physical environment, the relationships and the regime soften. This is at times tangible, embodied by the soft furnishings and plump cushions of the palliative care suite at HMP Wakefield, and the intentions for interior design in the proposed suite at HMP Leeds. It is also intangible; a softening of attitudes towards prisoners, a blurring of their identities in the minds of prison staff and the emergence of grey areas in matters of discipline which are usually black and white. The blurriness can extent to outside hospitals, where the importation of a dying prisoner, escorting officers and sometimes restraints, marks the bedside as both part of the hospital and a site of prison custody. In the prison, sympathy creeps in, changes relationships and informs care. Decency is repurposed to help inform understandings of how to make death 'as good as it could be'. Small changes to facilitate care soften the experience of imprisonment. The harshness of prison is never entirely dissipated, and the softening that occurs is neither dramatic nor universal. It occurs in response to factors associated with a prisoner that generate sympathy, such as his age, his previous behaviour or a concern for his family, and associated with his perceived proximity to death. It is limited by the lingering stigma associated with the prisoner and the importance of the security agenda within prisons.

This thesis also argues that in the perception of prisoners and staff, prison changes death, and death changes prison. The change to the prison is not dramatic; it is

closely linked to the tangible and intangible softening and blurring of boundaries considered above. However, this research has identified a number of ways in which the experience of dying and death is different because of the prison setting. The prison is affected by both an individual death and the cumulative effect of a number of deaths from natural causes. In comparison with deaths in the community, those occurring in prison custody are seen by prisoners and prison staff to reflect the priorities of the prison regime, the attitudes of people within the prison, especially staff, towards prisoners, the stigma of imprisonment and the dominance of the security imperative over issues such as care. These are all factors determining the response of prison regimes and personnel to dying prisoners, discussed below, which led participants in this research to argue deaths in prison custody were different from those in other circumstances because of the prison setting. However, this research also found that although deaths from natural causes have always been part of the prison, the increased frequency with which they are now occurring has led to changes to the prison that participants regard as long-term and enduring. Participants spoke about ways in which the prison had changed as a result of deaths from natural causes. These include the repurposing of space, the changing of working practices and the development of new concerns for staff and prisoners alike. Typically, each individual death temporarily interrupts the routine of the prison. Each dying prisoner's circumstances lead to small adjustments to facilitate their care, but the frequency with which deaths from natural causes in prison are now occurring, and the expectation this trend will continue, means that staff and prisoners alike report deaths from natural causes are resulting in lasting changes to how the prison operates.

This chapter elucidates these findings in relation to the research questions and explains how this research contributes to understandings of deaths from natural causes in prison. It also indicates how the conclusions reached relate to aspects of the operational practices around deaths from natural causes in prison custody that prison authorities and others may wish to address. The limitations of this research project are acknowledged, and recommendations are made for further research on related topics arising from this study which are beyond the scope of the research aims in this instance.

7.1 Research questions

This thesis has addressed two linked research questions:

> How do deaths from natural causes in prisons impact on prison regimes, culture and relationships?
>
> What determines the responses of prison regimes and personnel to dying prisoners?

How prison regimes and personnel respond to a death from natural causes is heavily influenced by the pre-existing culture, regime and relationships within the prison. However, the responses of prison regimes and personnel to deaths from natural causes also shape the ongoing culture and relationships in the prison, and have the potential to subtly and permanently change the prison regime. Prisoners notice and remember the treatment of their dying peers; if prison staff are perceived to have responded inadequately, then the stories subsequently circulating can add to tensions in staff-prisoner relationships. Adjustments made with regard to one dying prisoner can become part of a set of assumptions in the culture of the prison about how a dying prisoner should be treated or enshrined in understandings of the regime, of how the prison is operationalised. Some impacts of deaths from natural causes are long lasting, necessitating changes to prison buildings or new roles for staff, and thus affect the care of future dying prisoners. In both prisons studied, specific deaths had particular impacts and were expected by staff and prisoners to have changed future responses. Examples of this included the new ways of working introduced at HMP Wakefield, where Eddie was unusual in being permitted to stay on the wing as he became frailer and Neil's wife was permitted to stay with him overnight. Other deaths were remembered because the prisoner, for example Dean, William or Iain, at HMP Leeds, provoked sympathy amongst staff or was well-liked by prisoners, as Eddie was at HMP Wakefield. Their deaths became part of the culture of the prison and the lived memory of the staff and prisoners who had known them.

This research has focussed on the ways in which the challenges presented by the circumstances of dying prisoners affect the physical environment of the prison, attitudes towards prisoners, the implementation of prison rules, provision of services and resourcing and on staff identities and well-being. In doing so, what is being considered is the very nature of prison. It is therefore to be expected that there were many ways in which the prison regime, culture and relationships were unchanged by a death or the cumulative experience of an increasing number of deaths. There was an imperative to keep the regime running, to minimise the potential for disruption, especially after a death on a wing. Whatever physical changes were achieved, the

manifestations of carceral geography were still overtly present. The physical environment remained that of the prison, reflecting the priorities of the prison, even if of a previous prison-building era. With regard to relationships, staff and prisoners were both clear that although a terminal diagnosis may change a relationship, there was still an expected social distance which could not be bridged. The ways in which the prison regimes, culture and relationships were not affected by deaths from natural causes can be attributed to the steadfastness of the nature of prison. It is no accident that prison changes the experience of dying. Instead, it is the inevitable result of the nature of prison. Prison is after all a system of social control ("the maximum security prison represents a social system in which an attempt is made to create and maintain total or almost total social control" (Sykes, 1958, p.xiv)) which is not expected to significantly change around one prisoner because he is dying. However, even whilst most aspects of the prison remained unchanged, the softening described above was still evident. Acknowledging that prisons have long been considered institutions redolent with power (Foucault, 1991; Sykes, 1958), there are still a number of factors which serve to determine how power is used, and ways in which the exercise of power can negatively or positively change the experience of dying in prison. The examples of this will be considered next, before returning to the ways in which deaths from natural causes have been seen to impact on prison regimes, culture and relationships, despite the nature of the prison seemingly mitigating against this.

Factors determining response to dying prisoners

The central factor in how a dying prisoner was treated by prison staff was whether they attributed to him the dominant status of 'prisoner', 'patient' or 'person'. The statuses of 'patient' or 'person' served to ameliorate the underlying circumstance of the individual being a prisoner, someone deprived of their liberty with little hope of compassionate release despite a terminal diagnosis. Healthcare staff recognised the role of their own occupational culture in constructing the individual as a 'patient' and experienced tensions with the contrasting occupational culture of prison officers, who were more likely to regard dying individuals as first and foremost 'prisoners'. Prisoners in healthcare centres could be regarded by officers as being "patients before they are prisoners"[482], but healthcare staff experienced opprobrium from officers when their nursing practices reflected the intimacy and physical contact

[482] Fieldnote, Wakefield, 30/11/2018

inherent in caring for patients in the community. In this respect, a terminal diagnosis softens attitudes towards a prisoner, rather than dramatically changing opinions.

Each of these three statuses, ‘prisoner’, ‘patient’ or ‘person’, affected how the prison regime and personnel approached the dying prisoner or the prisoner after a sudden death. ‘Prisoners’ were security risks to be managed, in ways often affecting their care, especially through the use of restraints. They were extended only limited autonomy, and could be seen at death as “one of the roll”, a disrespectful term that upset prisoners and some staff. They were not ‘grievable’, and whilst prison officers may admit finding the circumstances of a death difficult, they did not mourn a deceased ‘prisoner’.

In contrast, when an individual dying in prison custody was seen as a ‘person’ or ‘patient’, informed by the occupational culture of the staff member relating to them, this served to provoke more sympathetic responses to the individual. The fact of a terminal diagnosis was itself often regarded by prisoners and staff as grounds for sympathy. Sympathetic responses were more easily generated if the dying individual was young, had good family relationships, was in prison for non-sexual offences, and was regarded as likable. In constructing someone as a ‘person’ or ‘patient’, staff were expressing a valuation of the individual as someone deserving of respect and care. This helped inform actions to improve their circumstances, such as making adjustments to the regime and providing them with perceived quality care, the meaning of which will be discussed below. A ‘person’ or ‘patient’ was also more grievable after death.

Care in prison was evaluated by staff and prisoners in three main ways. These reflected in part the construction of dying prisoners as ‘prisoner’, ‘patient’ or ‘person’. In trying to understand what would constitute quality end of life care, three discourses co-existed together: seeking to ensure equivalence with the medical and social care available in the community; seeking to match the expectations of the anticipated PPO investigation; and trying to make death “as good as it could be”. Each of these discourses by which staff and prisoners evaluated the care of the dying was loosely defined and highly subjective.

There were significant discrepancies, especially between staff and prisoners, over the extent to which care met the standards understood to be part of the most commonly accepted evaluation of care, the ‘ideal’ of equivalence with care in the community. Efforts to make deaths “as good as it could be” were informed by

notions of decency, a term that resonates within the prison service, and personal experiences of deaths in the community that recognised dying in prison was far from ideal. There were many examples of trying to make death in prison 'as good as it could be'. Attempts to make death 'as good as it could be' prioritised physical comfort, sought to ensure no restraints were used at the moment of death, valued the individual's privacy and prioritised the idea that no one should die alone. Care based on the anticipation of an investigation used understandings of the individual as first and foremost a 'prisoner', someone for whose treatment prison staff would have to account for after their death.

What was striking was the extent to which a caring culture existed in the prisons studied. Care in prison is often associated with healthcare staff, and contrasted with the discipline and control practiced by prison officers. This research instead concludes that care was both a responsibility and a source of pride for some staff in all roles and for some prisoners. For staff, it was additionally a professional task. In both prisons studied, there were many examples of caring about, taking care of, care giving and care receiving (Fisher and Tronto, 1990) seriously and terminally ill prisoners. It was this caring about that could have an emotional effect on prisoners and staff, something which led to considerable emotional labour.

There were ways in which the prison regime, culture and relationship did not soften when faced with a terminally ill prisoner. As seen throughout this thesis, prisons are places dominated by security considerations, and by the actions and regulations arising from the imperative to keep the prisoner population incarcerated and to prevent them from escaping, harming the public or harming each other. Security and rules were very significant in determining responses of prison regimes and personnel to dying prisoners. Security considerations shape carceral geography around dying prisoners, resulting in a physical environment still marked as a prison even when the death occurred in outside hospital. Staff were very aware of the limitations this posed to the care of dying prisoners, hence the desire to develop palliative care suites where regimes could be relaxed and the environment softened. The care provided in prison is subject to security considerations, through the need for approval on security grounds of actions and objects that will assist in caring for dying prisoners. The extent to which security considerations and the application of prison 'rules' determines responses to dying prisoners is ameliorated by the use of discretion, a vital tool in making adjustments to the regime, but potentially subject to idiosyncratic and arbitrary application.

Impacts of deaths from natural causes on prison regimes, culture and relationships

Deaths from natural causes impacted on the prison regime, culture and relationships in several ways. Some of these impacts were tangible and visible, others were less obvious and harder for staff and prisoners to elucidate. Many of these changes were only really noticeable to those directly involved, but they all contributed to the care of a terminally ill prisoner. Deaths from natural causes in prison custody also necessitated new tasks, and tasks which whilst not always entirely new involved more staff, especially at HMP Wakefield, as a result of the elevated number of deaths from natural causes in recent years.

One of the most prominent changes to the prison regime resulting from the increasing number of deaths from natural causes in prison custody was the presence of a palliative care suite in HMP Wakefield and the plans for similar provision at HMP Leeds. The desire to better meet the needs of dying prisoners had led to the repurposing of space within the prison and the redirection of resources towards the needs of this specific group of prisoners. Palliative care suites changed the physical environment of the prison, but were also places where there was an expectation of changes to the prison regime. They served to soften the carceral geography, to introduce softness and colour into a usually hard and drab setting. They also provided space in which the normal regime of the prison could at times be subverted by the needs of the dying prisoner, with doors being left unlocked, family being permitted to visit and stay, and healthcare professionals more freely deploying touch in the administration of care. There were other changes to the physical provisions the regime made for prisoners on the wings. Doorbells were situated next to beds so frail prisoners could more easily call for help, steps lowered, and approval given for more comfortable mattresses. Each of these changes subtly affected the expected prison regime in favour of providing for the comfort and ease of physically frail dying prisoners. There were other ways in which the regime ‘softened’. Small adjustments were made and normal wing routines could be speeded up or adapted. The need to make FLOs available for work with dying prisoners and their families could place an additional burden on the prison regime, as could responding to post-death investigations and attendance at subsequent coroner’s court hearings where staff could be unavailable for their usual tasks for several days.

Deaths from natural causes also subtly changed the culture of the prisons studied. As discussed above, care quietly permeated the prison culture but was especially

marked around those prisoners who were frail or known to be dying. It was also extended to those thought to be affected by a death, although not universally or consistently. In HMP Wakefield especially, the prison culture was marked by an awareness of death and dying, reflected in the willingness of prisoners and staff to talk to the researcher about their experiences or concerns. The experience of living and working with prisoners who had died was so common that it had changed the culture of the prison, and changed attitudes towards subjects often regarded as sensitive.

The culture of the prison was also different because new tasks were placed on or accepted by prison staff, particularly officers, who found themselves pushing wheelchairs or helping healthcare colleagues turn prisoners in bed. The care of the family, by family liaison officers but also sometimes prison chaplains, became more important, and the relationship between the family and prison altered, with far more contact and involvement with a dying or deceased prisoner's family than was usual with prisoners' families in other circumstances. Officers found themselves facilitating visits in healthcare centres rather than Visits halls. They also found themselves involved in more post-mortem investigations, in dealing with the problems regarding communicating prisoners' wishes not to be resuscitated whilst respecting medical confidentiality and in supporting their colleagues after a death.

The frequency with which deaths from natural causes were occurring had led to more 'bedwatch' duties for officers and a greater emphasis being placed on the correct use of restraints, in accordance with the accepted standards set by the Graham Judgement. Restraints had become a significant issue within both prisons studied. For staff this was because their misuse could offend a sense of what constituted decency, but also because there was a fear that if used inappropriately the prison may be criticised after a death by the PPO. For prisoners, restraints conveyed the shame of stigma, embodied a lack of care and were an affront to their dignity. Although restraints were used on prisoners needing treatment in 'outside' hospital who were not terminally ill, cultural standards around the respect due to the dying made these issues more significant.

Deaths from natural causes also changed relationships. In the high security prison, where prisoners may be resident for several years, there was an awareness that long-term relationships developed, between prison officers and prisoners, but also between prisoners. The circumstances of a dying prisoner provided an opportunity for his peers to express and develop their caring side, to make amends for their

past, and in some cases to embody their feelings towards a prisoner in practical actions. More intimate relationships developed between prisoners as a result. Relationships could also be changed negatively when a prisoner was dying, with their frailty being regarded as an opportunity for exploitation by some of their peers. For staff, especially officers, the circumstances of a dying prisoner reduced the social distance between them. Officers felt more sympathy in their relationships with dying prisoners, although this was sometimes seen as an expected part of professionalism, to the extent that it was performed even if the officer struggled to align their deeper emotions to the perceived occupational norms. Officers reported allowing dying prisoner 'more grace', softening their discipline approaches because of the prisoner's circumstances, but struggled to show they were upset by a bereavement. For both staff and prisoners, memories of such deaths could come up years later. There was a need for support to be offered, but mixed views on what was available and a tendency to expect formal offers but in practice seek informal support.

7.2 Contribution and impact

This research project has collected data that provides a rare insight into death and dying in prison. Whilst the need to research deaths in prison custody is recognised within prison sociology (Liebling, 2017), there have been no studies of deaths from natural causes that consider the impact on the prison as an institution. This aspect has been overlooked. Even within this study, changes to the normal regime, whilst frequently observed, were often taken for granted by participants as the right thing to do and therefore underreported by them. This made the ethnographic elements of this research more significant; only through participant observation did the extent of the adjustments being made and the impact of these deaths become apparent.

The research has identified a number of factors relevant to determining the responses of prison regime and prison personnel to dying prisoners, and several ways in which deaths from natural causes impact on prison regimes, culture and relationships. In doing so, it contributes to prison sociology by concluding both that deaths from natural causes in prison custody soften prison regimes, culture and relationships and that prison changes death and death changes prison. The softening occurs in both visible, tangible ways, but also intangibly, and it is this blurring which informs the responses of prison regimes and personnel to dying prisoners.

The research makes a further original contribution to prison sociology by challenging and contradicting much of the existing literature, primarily from health sciences, which juxtaposes the philosophy of ‘care’ attributed to healthcare professionals in prison with the ‘control’ or ‘discipline’ philosophy assigned to prison officers. Instead, this research demonstrates care quietly permeating the prison culture, especially with regard to efforts, expressed primarily by prison officers and governors, to make death in prison ‘as good as it could be’. This research is therefore significant because it considers palliative care in prisons more holistically than existing studies, which have often been limited to the medical care of terminally ill prisoners and tended to focus on the experiences of healthcare professionals. Prison officers are seen to be meeting the psychosocial needs of terminally ill prisoners. This finding is unexpected in the context of previous studies of palliative care in prison, which have focussed on the opinions of healthcare professionals, but perhaps less unexpected in light of previous studies of prison officers’ performance of care and their relationships with prisoners more generally. Appropriate palliative care includes meeting the psychosocial and spiritual needs of prisoners and their families. In the context of the prison, this means considering, as this research does, locations other than the prison’s healthcare centre in which end of life care is delivered. It also means it is important to have considered the interactions between staff other than healthcare professionals with the dying prisoner and between other prisoners and prisoner-carers with the dying prisoner.

The research findings have particular relevance because the number of deaths from natural causes, associated with an ageing prison population, is predicted to continue to increase. As a result, this research has the potential to be useful to those engaged in the management of prisons (including prison governors), in the care of prisoners, and in the support of prison staff, prisoners’ families and friends. It is also of relevance to the Prison and Probation Ombudsman, as the body responsible for investigating prisoners’ deaths.

With regard to operational and policy matters, these findings suggest a number of areas for attention which are likely to affect several prisons. These include the contradictions and oversights in PSIs, and the current difficulties in obtaining compassionate release for dying prisoners, both of which can only be addressed at a national level. This research demonstrates that the compassionate release system is not working, as evidenced by the way both staff and prisoners at HMP Wakefield no longer expected compassionate release to be granted, even though they still

completed the necessary paperwork. Reform is needed in particular to address the mismatch of expectations between the prison service and palliative care professionals with regards the requirement to specify that death is anticipated within three months. This is at odds with current medial practice and serves as a barrier to compassionate release applications. However, granting compassionate release is politically sensitive. Prison staff are themselves aware of the risks and anxious to avoid a situation where a prisoner granted compassionate release commits further crimes. Some measure of when compassionate release is appropriate is clearly needed, although it's impossible to conclude that the current measures are suitable given how rarely release is granted. Other barriers to compassionate release, such as resolving which local authority should cover the costs, should be easier to address.

The research also highlights the continuing need, despite the Graham Judgement, to work to ensure the appropriate use of restraints when terminally ill (or other) prisoners are transferred to NHS facilities outside the prison. It also demonstrates the ways in which the expectation of an investigation after death can shape the care of the dying prisoner as the prison seeks to forestall possible criticism. This can, perhaps understandably, lead to a better standard of care for the prisoner, but it can also lead merely to better record keeping. In some cases the expectation of an investigation had unexpected consequences such as the removal of extraneous medical equipment from the room prior to death in an attempt to avoid it being seized as part of the investigation. The expectation of an investigation also changed the care of the body after death and potentially served to make a death emotionally harder for prison staff, especially healthcare staff, and the prisoner's family, required to leave the deceased immediately after a death since the room was regarded as a crime scene.

At a local level this research shows the on-going tensions between prison officers and healthcare professionals over the construction of the dying prisoner, which can adversely affect the care of the prisoner and employment experiences, particularly of nurses. It also highlights the need to ensure the appropriate use of discretion when adjustments are made around dying prisoners that rely on feelings of sympathy informed by the personal characteristics of the prisoner, and so risk becoming arbitrary and discriminatory. Lastly, the research serves as a reminder that prison staff and prisoners alike expect formal offers of support after a death has occurred, and feel undervalued if these are not forthcoming, even if the support they

accept comes from informal sources. For the two prisons studied, the research findings suggest two further aspects of the care of dying prisoners potentially needing attention. HMP Leeds could learn from the experience of other prisons, including those housing higher risk prisoners, to enable the use of syringe drivers and Oramorph in the prison. HMP Wakefield could find it beneficial to use practices developed in other prisons for communicating the existence of a prisoner's DNR wishes amongst staff.

7.3 Limitations and recommendations for further research

One of the most significant limitations of this research is that although the increasing number of deaths from natural causes in prison custody makes research so necessary, it also means the situation is evolving. Prisons are amending their practice in response to a developing understanding of the needs of terminally ill prisoners, to changing external guidance (such as the *Ambitions for Palliative and End of Life Care*) and because, like HMP Wakefield, they are simply getting more practice at dealing with deaths from natural causes and are therefore operationalising new practices and procedures. These factors mean that whilst this thesis may accurately capture the situation in 2016–9, its findings may become dated. Furthermore, although the research was conducted in two prisons, carefully chosen because they had both contrasting and similar characteristics, as discussed in chapter three, it cannot encompass the current situation in all prisons, and only seeks to represent the impacts of and responses to deaths from natural causes in prison custody in one jurisdiction, England and Wales. It should also be noted that some of the adjustments made to meet the needs of dying prisoners were also in place for their peers who were seriously ill or frail from other reasons, and did not exist solely because of awareness of a terminal diagnosis.

The aim of this research project was to analyse the impact on prison regimes, culture and relationships of the growing number of prisoners dying from natural causes and to explore the factors influencing responses within the prison to dying prisoners. In the course of this research, related questions arose which could not be included in these aims. Firstly, this research suggests further study is needed on the experience of family members bereaved when a prisoner dies of natural causes. This would help address whether they feel supported by the prison, including by the family liaison officer, and whether practices such as being permitted to stay in a prison overnight with their dying family member are valued. Linked to this there could also be further study on the experiences of the FLO. This project suggests the

increasing number of prisoners dying from natural causes is presenting FLOs with new challenges in terms of workload, but also in terms of the emotional labour associated with the deaths of prisoners who have committed sexual offences against family members. The relationship between a prison and a prisoner's family seems to change in the circumstances of a death from natural causes, and this arguably warrants further attention. Secondly, the 'bedwatches' observed during this research highlighted the need to identify how the experiences of prisoners, healthcare professionals and prison staff can be improved when the prisoner is receiving medical treatment outside of the prison. It is clear from this study that the two sets of professionals, coming from very different institutional objectives, bring conflicting priorities to their work with the prisoner on a 'bedwatch' which can potentially affect the treatment of the prisoner. Lastly, this research has highlighted lesser gaps in the existing literature, including in the UK context how gender may influence prison officers' attitudes to sex offenders, and the role of gender in the style of caring provided by prison officers.

7.4 Final remarks

There is, sadly, no simple answer at a policy level to what should be done in response to prisoners dying from natural causes. Some things could be improved, as outlined above, but there are more fundamental structural difficulties which are harder to address. At heart, the issue is that dying prisoners need different things. For some, compassionate release is desirable, and needs to become less rare. For others, compassionate release would remove them from the place that has become their 'home', and potentially simply move them to another institution, one where they did not have such long-term relationships with staff willing to provide their psychosocial care at the end of life. Staff and prisoners talked about an ideal 'secure hospital' where prisoners who were physically frail could be housed. Others would resent being with only their elderly and frail peers as they reached the end of life. Even if such a facility existed, there would still be the question of when a prisoner should move to it, and who would decide.

What should happen to dying prisoners is not an easy issue to address, but one where the responses reflect society's priorities and values. Prisoners needs differ, but in meeting them, the criminal justice system has also to remember the expectations of the public, the needs of victims and the requirement to act with fairness. What is currently happening, however, presents complex moral and ethical questions which need addressing. Is prison the right place to die? Is it right to leave

individual prisons and individual prison staff to try to find case-by-case solutions? Should remand prisoners be treated differently at the end of life? Further discussion at a policy level is clearly needed, both to support the staff who are trying to respond appropriately to the needs of dying prisoners in their care, but also to ensure the prison service in England and Wales continues to respect the humanity of the people it accommodates.

For many of the prisoners involved in this research project, the possibility of dying in prison was something they acknowledged, did not welcome, but often accepted. What concerned them more was how imprisonment would affect their experience of dying, the care they would receive, and the way they would be treated by those around them. The issues they spoke about reflected their situation as prisoners, and the workings of a total institution (Goffman, 1961) and the stigma associated with their imprisonment (Goffman, 1963). They saw contrasts with how dying in the community might be envisaged. They recognised being in prison would change the experience of dying, as did the prison staff, officers, governors, nurses and chaplains who worked with them. Their willingness to participate in this research reflects the urgency with which the challenges arising from prisoners dying of natural causes need to be addressed. They knew the experience of dying and death to be different because of the prison setting and saw ways in which, for the immediate moment or in the longer term, prison regimes and culture were altered by responding to the needs of dying prisoners. Deaths from natural causes in prison custody soften prison regimes, culture and relationships and this blurring informs the responses of prison regimes and personnel to dying prisoners. In this respect, prison changes death, and death changes prison.

Appendices

Appendix 1: Participant Information Sheet

Please see next page.

Dying Inside: Deaths from natural causes in prison culture, regimes and relationships

Information

Why is the research being done?

Across the UK, there is an increase in the number of prisoners dying of natural causes (for example cancer, heart attacks or liver disease). I want to describe how this affects prisons and the people within them, and look at what influences how a prison regime and prison personnel respond to dying prisoners. By understanding this better, I hope that possible problems can be highlighted and good practice recognised.

As a result, new Prison Service instructions, working policies and support might be introduced.

Who is the researcher?

My name is Carol Robinson. I am studying for a doctorate at the University of York. My study is independently funded by the Economic and Social Research Council. I am not doing this research on behalf of the prison service. My research plans have been approved by NOMS, the NHS and the University of York. I've done some research in prisons before, and I've also worked as a prison chaplain, which is how I became aware that more and more people are dying of natural causes in prison.

Why have I been chosen?

You are being asked to be involved in this study because you spend time in places where prisoners who are seriously ill or approaching the end of the life are together with the prison staff. This includes health care centres, bedwatches, hospital visits and wings where these prisoners are living. Being asked to be involved if you are a prisoner does NOT mean you are seriously ill or near the end of life. The researcher has no access to your medical records or to any prison service record about you.

If you've been asked to be interviewed, it's because you have worked with prisoners who are terminally or seriously ill and have a role that brings you into contact with prisoners in these circumstances.

What will being involved in the research mean?

For most people, it will just mean carrying on with what you are doing, but with me present. If you give your permission, then I will be in the health care centres, hospital visits and on the wing, seeing what happens and taking notes about the space, the activities that take place and any problems or issues that emerge. I won't be around during consultations with a doctor or if it gets in the way of treatment. I won't ask you to do anything different. I'll try not to interrupt what you are doing, but you should feel free to talk to me.

I'll be asking some people if I can interview them. This will give chance for a longer conversation about experiences of working with terminally or seriously ill prisoners, and times when a prisoner has died of natural causes. If you are happy to be interviewed, I will have some questions to prompt you, but want to hear your views on the topic. The interview will last about 45-60 minutes. It will be recorded, if you give permission. It might not be possible to interview all staff who are willing to help with this research so staff members will be asked to complete a selection questionnaire.

Do I have to take part in the study?

It is completely up to you. If you are a prisoner, whether you want to take part or not won't affect your chances of parole or your treatment in prison, you don't have to be involved as part of your sentence plan and it won't count towards the prison's targets for purposeful activity. Anyone who chooses to take part now can change their mind in the future without having to give a reason. If you're being interviewed, then at the end of the interview, I'll check if you're happy for me to include everything you've said in the study, or whether there's anything you'd like to be excluded. If at any time it seems you are unable to make a decision about being part of the study, for example because you have become very unwell, then I'll withdraw.

Are there any risks involved in taking part?

The research is looking at the subjects of death and dying. Depending on your circumstances, this might trigger some unhappy or upsetting thoughts. However, you do not have to talk about anything you do not wish to and you can ask me to leave at anytime. If you are being interviewed you won't have to answer any question you don't want to and we can stop or take a break at any time. There will be chance to discuss anything you may have found difficult with me. Both the Listeners scheme and the Staff Care Team will be told about this research (but not who is taking part) and if you want, you can talk to them too.

Are there any benefits in taking part?

You may feel that it is helpful to talk about your experiences. You will be contributing to the understanding of an important issue and your help will be greatly appreciated, but you can't be paid for it.

What will happen to the information I give you?

All your personal data will be handled in line with the Data Protection Act (1998) and with the University of York's policies.

If you're being interviewed, a recording of the interview will only be made with your agreement and then using an encrypted Dictaphone. I'll transfer the electronic file of the recording on to a password protected store as soon as possible (within two days) and then delete it from the Dictaphone. Whilst your interview recording is still on the Dictaphone, I'll keep it with me, or in a locked cupboard. The recording of the interview will not be shared with anyone. I'll type up what you've said in a way that removes any names or information that might mean you or someone else could be identified and the electronic copy of this transcript will be stored securely (and password protected) at the University of York for analysis and reporting.

If I'm accompanying you, I'll take handwritten notes from time to time about what's happening. I won't include your name in these notes, or anything that might identify you. I'll keep my notebooks locked in a cupboard when I'm not using them. I'll type up my notes in a way that removes any information that might mean you or someone else could be identified. The electronic copy of this transcript will be stored securely (and password protected) at the University of York for analysis and reporting.

The selection questionnaires that staff complete prior to being interviewed will be kept in a locked drawer in the prison. A summary will be produced, without any personal information, which will then be transferred by email to the University of York, where it will be stored securely (and password protected). Consent forms will be scanned and the electronic copies also be stored securely (and password protected) at the University of York. The originals will then be shredded. The electronic files of the scanned copies will be be kept, securely and password protected, for 6-12 months after the study has ended, and then destroyed.

Will what I say be kept confidential?

The information you share will normally be kept completely confidential. However, I will be obliged to pass on to a member of staff any information regarding:

- A threat to cause harm to yourself or to others
- A serious threat to prison security
- Illegal activities, malpractice or breaches of prison rules

In all other circumstances, everything you say will remain confidential.

Will my contribution remain anonymous?

I'll do my best to make sure it's anonymous. When I write up the information or if I'm sharing your words or your experiences in any reports, publications or talks about the research I won't use your name or any details about your life which I think would 'give away' who you are. I won't describe you in any way that could be recognised. If I use what you've said, I'll not use your exact words if I think you might be identified by them, for example because of what you say or how you say it.

You need to be aware that it is possible that people may try to guess who has taken part in the study. This is particularly the case if there are not many people in your job. For this reason, staff members and prisoner-carers will be asked if their role can be mentioned. I will use the name of the prison because people will easily guess where I've done the research.

How do I agree to take part in the study?

I will ask you how long you need to decide whether to take part. If you do agree to take part, you will be asked to complete a consent form, confirming that you understand what the study involves and have had a chance to discuss any questions with the researcher.

What if I change my mind about taking part?

You are free to change your mind at any time. If I've been with you taking notes, you can ask me to ignore something without having to explain why and I will destroy the relevant part of my notes. If I've interviewed you, you can request that either part or all of the content of the interview is removed from the study, without having to explain why. Changing your mind will not be held against you or disadvantage you in any way.

What will happen to the results?

I will use the information I have gathered, without anything to identify who you are, to write up my doctoral thesis, and in publications and talks about the research. I will produce a short summary to give to everyone who has taken part. With

your permission, I will also give a written copy of the interview, without any personal information, to the UK Data Service, and allow limited access to other accredited researchers. In line with University of York policy, the UK Data Service will store this anonymised information for a maximum of 10 years.

What if I want more information about the study, or want to complain about some aspect of it?

If you would like more information or have any questions or complaints about the research please feel free to speak to me directly. I can be contacted via Safer Custody or the Prisoner Information Desk.

You can also talk to my academic supervisors: Dr Ruth Penfold-Mounce and Prof. Maggie O'Neill, by writing to them c/o the prison's Safer Custody team.

Thank you for your interest. If you have any further questions at any stage of the research, please do not hesitate to ask me.

Appendix 2: Consent form — Interviews

Dying Inside: Deaths from natural causes in prison culture, regimes and relationships

Consent form for people being interviewed

Please write your initials in the box to show you agree with the statements

1. I have read the information sheet. I have had the opportunity to consider the information and to ask questions. ☐
2. I understand that my participation is voluntary and that there is no advantage or disadvantage from taking part in the research or not. ☐
3. I understand I am free to withdraw at any time, without having to give any reason, and without any negative effects. ☐
4. I understand that if at any time I lose the ability to agree to be part of the study, I will be withdrawn from the research. If this happens, I am happy for the information collected before I lost the ability to consent to be used in the study. ☐
5. I understand that my words may be quoted anonymously in publications, reports, web pages, and other research outputs. ☐
6. I am happy for the interview to be audio-recorded and understand that this recording will not be shared with anyone else. ☐
7. I understand that if I reveal information about illegal activities, risks to prison security, myself or others, malpractice or breaches of prison rules, my confidentiality cannot be guaranteed. ☐
8. I understand that the information I provide will be used to support other research in the future, and may be shared anonymously with other researchers if they agree to preserve the confidentiality of the information. ☐
9. [Staff members only] I agree to my job title being used in reports about the research. ☐
10. I agree to take part in the above study. ☐

______________________	______________________	______________________
Name of Participant	Date	Signature
______________________	______________________	______________________
Name of Researcher	Date	Signature

[One copy for participant, one copy for researcher]

Appendix 3: Consent form — Observation

Dying Inside: Deaths from natural causes in prison culture, regimes and relationships

Consent form for people being observed

Please write your initials in the box to show you agree with the statements

11. I have read the information sheet. I have had the opportunity to consider the information and to ask questions. ☐
12. I understand that my participation is voluntary and that there is no advantage or disadvantage from taking part in the research or not. ☐
13. I understand I am free to withdraw at any time, without having to give any reason, and without any negative effects. ☐
14. I understand that if at any time I lose the ability to agree to be part of the study, I will be withdrawn from the research. If this happens, I am happy for the information collected before I lost the ability to consent to be used in the study. ☐
15. I understand that my words may be quoted anonymously in publications, reports, web pages, and other research outputs. ☐
16. I understand that if I reveal information about illegal activities, risks to prison security, myself or others, malpractice or breaches of prison rules my confidentiality cannot be guaranteed. ☐
17. I understand that the information I provide will be used to support other research in the future, and may be shared anonymously with other researchers if they agree to preserve the confidentiality of the information. ☐
18. [Staff members only] I agree to my job title being used in reports about the research. ☐
19. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Researcher	Date	Signature

[One copy for participant, one copy for researcher]

Appendix 4: Selection questionnaire for staff

Dying Inside: Deaths from natural causes in prison culture, regimes and relationships

Thank you for your interest in participating in this research. To help ensure that the interview time is used as efficiently as possible, please answer the following (hopefully easy!) questions, and return this form to Carol Robinson c/o Safer Custody. Your answers will not be seen by anyone else.

ABOUT YOU

Name

Age (please tick one)

☐ Under 25	☐ 36-45	☐ 56-65
☐ 25-35	☐ 46-55	☐ Over 65

Gender

☐ Female ☐ Male ☐ Other

How many years have worked in prisons? (approximately)

How long have you worked at HMP <prison name>? (approximately)

What is (are) your current role(s)? (eg personal officer, chaplain, governor, training facilitator….)

ABOUT YOUR EXPERIENCE WITH TERMINALLY OR SERIOUSLY ILL PRISONERS

Have you got experience of any of the following? Please tick all that apply and give more details where asked.

Being involved with end of life preparations for a prisoner ☐

How frequently? Rarely/Occasionally/Often/Regularly (please circle one)

How recently? (approximately)

What was your role?

Working with prisoners in the prison's healthcare centre who a terminally or seriously ill ☐

How frequently? Rarely/Occasionally/Often/Regularly (please circle one)

How recently? (approximately)

What was your role?

Accompanying a prisoner on a hospital visit ☐

How frequently? Rarely/Occasionally/Often/Regularly (please circle one)

How recently? (approximately)

What was your role?

Escorting or visiting a prisoner who is terminally or seriously ill on a bedwatch in outside hospital ☐

How frequently? Rarely/Occasionally/Often/Regularly (please circle one)

How recently? (approximately)

What was your role?

Working on a wing with prisoners who are terminally or seriously ill ☐

How frequently? Rarely/Occasionally/Often/Regularly (please circle one)

How recently? (approximately)
What was your role?

Sitting with a dying prisoner within the prison
How frequently? Rarely/Occasionally/Often/Regularly (please circle one)
How recently? (approximately)
What was your role?

Other involvement with terminally or seriously ill prisoners
Please give details, including frequency and how recently you've had this involvement

OTHER INFORMATION
What is the best way to contact you in the prison? Are there particular days you do or don't work? Where can I usually find you?

Many thanks for your help. I will be in touch with everyone who completes a form, but if I have lots of offers to help, I may not be able to interview everyone.

Appendix 5: Interview guide for staff interviews

Intro
Thanks for coming.
Info sheet - i.e. purpose, confidentiality, recording
Consent form
Might ask obvious questions, but want to include info in the research.

Opening questions
To start, can you tell me how come you came to work in a prison?
And how come you started working with prisoners who are terminally or seriously ill?

[Establish what role(s) the interviewee has in connection with terminally and seriously ill prisoner. Start with most relevant role one and ask re subsequent ones as relevant]

Case studies
***I'd like now to think about a specific time when you've worked with a prisoner who was dying of natural causes. Take your time to choose an example.
Can you talk me through what happened?
    [What were the circumstances? What happened next?
    [What did you do? Is this what you expected to do?]
Were there any particular problems looking after the prisoner?
    [How did/could you address them?]
Is there anything that would have helped?
Were there any impacts or adjustments to the prison regime?
Were there any ways in which you think the needs of the dying prisoner were met differently because they were in prison?
How did you feel about the prisoner's death? [How did you deal with those feelings?]
What was the impact of the prisoner's death? [prompt re relationships, regime changes, PPO findings etc]

Is there any reason the example you've talked about stands out? How typical was it?

[***REPEAT FOR DIFFERENT ROLES IF NECESSARY]

[If more than one role in the prison]
Is there a connection between your roles in the prison?

Thinking more generally…
When you're working with someone approaching their natural death, is there anything that makes it harder or easier for you to work with them?
Do you think your gender has an influence on how you work with a prisoner dying of natural causes?
How do other people in the prison view what you do?
Do you feel supported in what you do? Where does the support come from?
How do you feel about your role?

Conclusion
That's pretty much all my questions – thanks

I hope it's been OK being interviewed. Was there a particular reason why you offered?

Is there anything else you wanted to say?
Have you got any questions for me?
Are you OK with me using everything we've talked about in my research?

Reminder re Care Team.
Reminder re transcription and anonymising data.

Appendix 6: Interview guide for interviews with prisoners employed as carers

Intro
Thanks for coming.
Info sheet - i.e. purpose, confidentiality, recording
Consent form
Might ask obvious questions, but want to include info in the research.

Opening questions
To start, can you tell me how come you came to work caring for prisoners?

Have you cared for a prisoner who is terminally ill or who has died?

Case studies
***I'd like now to think about a specific time when you've worked with a prisoner who was dying of natural causes. Take your time to choose an example.
Can you talk me through what happened?
    [What were the circumstances? What happened next?
    [What did you do? Is this what you expected to do?]
Were there any particular problems looking after the prisoner?
    [How did/could you address them?]
Is there anything that would have helped?
Were there any impacts or adjustments to the prison regime?
Were there any ways in which you think the needs of the dying prisoner were met differently because they were in prison?
How did you feel about the prisoner's death? [How did you deal with those feelings?]
What was the impact of the prisoner's death? [prompt re relationships, regime changes, PPO findings etc]

Is there any reason the example you've talked about stands out? How typical was it?

[***REPEAT FOR DIFFERENT EXAMPLES IF NECESSARY]

Thinking more generally…
When you're working with someone approaching their natural death, is there anything that makes it harder or easier for you to work with them?
How do other people view what you do?
Do you feel supported in what you do? Where does the support come from?
How do you feel about your role?

Conclusion
That's pretty much all my questions – thanks

I hope it's been OK being interviewed. Was there a particular reason why you offered?

Is there anything else you wanted to say?
Have you got any questions for me?
Are you OK with me using everything we've talked about in my research?

Reminder re Listeners scheme
Reminder re transcription and anonymising data.

Appendix 7: Prisoner/staff information notices

HMP Leeds

From next week, Carol Robinson from the University of York will be present in the establishment to look at the effect of deaths from natural causes on prison regimes, culture and relationships. Carol has worked in prisons before and will be carrying keys. Her aim is to observe practice and interview staff and prisoners working with terminally and seriously ill prisoners. Her research has been approved by NOMS and the NHS. She expects to be with us for several months. Your cooperation with her research will be greatly appreciated.

Over the next few weeks, Carol will be attending meetings and introducing herself. She is very happy to answer any questions you may have about the research. She can be contacted via Safer Custody.

HMP Wakefield

From next week, Carol Robinson from the University of York will be present in the establishment to look at the effect of deaths from natural causes on prison regimes, culture and relationships. Carol currently works within the high security estate. Her aim is to observe practice and interview staff and prisoners working with terminally and seriously ill prisoners. Her research has been approved by NOMS and the NHS. She expects to be with us for several months. Your cooperation with her research will be greatly appreciated.

Over the next few weeks, Carol will be attending meetings and introducing herself. She is very happy to answer any questions you may have about the research. She can be contacted via Safer Custody or the Prisoner Information Desk.

Glossary

Term	Explanation
1s, 2s, 3s etc	Used to refer to the floor levels within prison buildings, especially in accommodation units. The 1s is the first/ground floor, the 2s is the floor above, the 3s the floor above that etc.
Basic	Part of the Incentives and Earned Privileges scheme (see below) which governs prisoners' entitlement to privileges including extra visits, access to television, the right to wear their own clothes etc. Basic is the lowest level, used as a punishment for not complying with prison regulations or for bad behaviour.
Bedwatch	Slang term for the prison officer escort of a prisoner who is an in-patient in a hospital setting.
Cat A	A classification, formally *category* A, used for prisoners whose escape would be highly dangerous to the public or the police or the security of the State and for whom the aim must be to make escape impossible (Garton Grimwood, 2015).
Cat B	A classification, formally *category* B, used for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult (Garton Grimwood, 2015).
Centre	The central atrium of a radial prison design, linking the wings. In both the prisons studied, this was a large area, the full height of the prison.
Cleaner's Office	The area or office in a prison, typically very small, used by the prison officers with the daily responsibility for the

	domestic function of the wing. Often the first port of call for prisoners with queries about practical needs.
CM	Custodial Manager. The senior uniformed rank amongst prison officers.
Detail	The department within a prison that produces the daily rota detailing specific officers to specific tasks/functions.
Escape pack	The information pack taken by officers when escorting a prisoner who has been assessed as posing a risk of escape to an out-patient or in-patient appointment at a hospital or hospice outside of the prison. An escape pack must always include the prisoner's current description, 4 up to date photographs (From PSI 33/2015).
Escort	The officers accompanying a prisoner to an out-patient or in-patient appointment at a hospital or hospice outside of the prison.
FLO	Family liaison officer. The member of staff, typically a prison officer, whose role is to liaise between the prison and the family of a prisoner. In speech, each letter is spelled out.
Governing Governor	The most senior member of staff in a prison, known in the private sector as the Director. Sometimes referred to as the Number One to distinguish him or her from other staff of governor grade.
H3	The area in HMP Leeds used to house prisoners with medical and social care needs such that normal wing location was not suitable for them. 'H' refers to the block, '3' to the landing.
IEP	Incentives and Earned Privileges. A tool of prison management that gives prisoners the opportunity to gain

	benefits, based on their good behaviour, participation in constructive activity and work towards their own rehabilitation. Includes an entry level together with three levels of privileges; basic, standard and enhanced.
Listeners	Used to refer to both the peer support scheme and the individual prisoners providing peer support aimed at reducing self-harm and suicide in prison. Listeners are prisoner-volunteers trained and supported by the Samaritans.
Natural causes	Deaths that are *not* suicides or unlawful killing, and do not result from accident or misadventure or the misuse of drugs or alcohol. Deaths from natural causes may be expected or unexpected, and result from physical health issues such as cancers, organ failure, strokes or degenerative disease.
Patrol State	The condition of a prison in which all prisoners are locked in their cells, typically following a roll check, overnight or to facilitate staff breaks and the handover between staff shifts.
PID workers	Prison Information Desk workers. Prisoners tasked with communicating information and responding to queries about the regime from prisoners.
PID Desk	Prison Information Desk. The base for PID workers, usually somewhere conspicuous in each residential unit.
PSI	Prison Service Instruction. Part of the rules, regulations and guidelines by which prisons operate. Typically organised thematically with a separate PSI for each topic and a fixed expiry date by which they should be reviewed (Ministry of Justice, 2019).
PSO	Prison Service Orders. Issued until August 2013, PSOs are long-term mandatory instructions intended to last indefinitely.

	Some have subsequently been cancelled or replaced by PSIs (Ministry of Justice. 2019).
PPO	Prison and Probation Ombudsman. The official body tasked with independently investigating complaints made by prisoners, and investigating deaths of all prisoners.
Servery	The area on a wing from which prisoners collect meals.
SO	Senior Officer. The uniformed prison officer who supervises the work of other prison officers, but is junior to a CM.
Stores	The function responsible for providing basic supplies to prisoners, such as bed linen and clothing, in line with their entitlement.
Visits hall	Room used for prisoners' visits from family and friends. Housed within the prison walls, but in a separate building from the wings, workshops or healthcare centre and so harder for prisoners with limited mobility to access.
Wing	The residential using of a prison, typically housing large numbers of prisoners.
Wing Reps	Prisoners appointed to represent their peers on relevant fora as required on a range of matters such as anti-bullying, catering, equality and diversity and healthcare.
Works	The department responsible for maintenance of the prison fabric.
Unlock	Period of time during which prisoner's cell door can be unlocked, typically for association with other prisoners or to facilitate domestic tasks.

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