'Physically efficient, psychologically detached': prison healthcare staff experiences of, impacts from, and strategies for, working with prisoner self-harm and suicides.

Sara Hyde, BA, PGDip, MA

Thesis submitted to University of Nottingham for the degree of Doctor of Philosophy, September 2024

Rainbow over HMP Pentonville, March 2023.

Total word count: 99, 993
Word count (excluding references and appendices): 85, 894

Setting the scene

'And, it sounds really callous, but, I'm trying to explain […] I've got 90 men on an open wing, 60 of them telling me they're going to cut themselves. How do I assess who is serious and who I need to give my attention to? […] And when you're being asked questions of but how did, why did you not give him an extra five hours of support? […] These kind of questions we're trying to explain - that's not how prison works.'
Sullivan (A, former voluntary sector prison healthcare worker)

Done, done and I'm on to the next one
Done, done and I'm on to the next one
Done, I'm done and I'm on to the next
Done, done, on to the next one
Done, I'm done and on to the next one
Done, done, on to the next one
Done, I'm done and I'm on to the next
Hey, don't let it go to waste, I love it but I hate the taste
Weight keepin' me down.
All my Life, Foo Fighters

'I think of going to court… it's not just the fact it's just a stressful occasion […] One, it's distressing because somebody's died, and, secondly, it's stressful because you're going into the unknown really […] And I think the other thing is that most people, probably, when they're there, trying to do the right thing, are always thinking about all the stuff that's stacking up at work…'
Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

It took a devastation to find hope. Hope is not a neutral position. It is adversarial. It is the warrior emotion that can lay waste to cynicism. Each redemptive or loving act, as small as you like… keeps the devil down in the hole. It says the world and its inhabitants have value and are worth defending. It says the world is worth believing in. In time, we come to find that this is so.
Nick Cave (Red Hand Files, 2022)

'…it was a probably a couple of weeks later where I just started to think - that was really, that was a close call and it made me feel... a bit wobbly, really about things like clinical competence and what might have been different and how would I have reacted and I had to really quite, I had to work to keep it all in context really because it, there was a danger that it would have all have spiralled out of control a little bit, but... I worked through that and I talked to somebody, talked to the nurse who had been with me at the time and it wasn't just me that felt like that, so that made it feel a little bit better.'
Morgan (A, former RGN)

Rarely, if ever, are any of us healed in isolation.
bell hooks (1999)

this wheel of many parts, that can rise and spin
over and over again,
full of gorgeous life.

Ah, world, what lessons you prepare for us,
even in the leafless winter,
even in the ashy city.
I am thinking now
of grief, and getting past it;

From *Starlings in the Winter* by Mary Oliver

Abstract

This thesis has considered the experiences of prison healthcare staff working with prisoner suicide and self-harm in 21st century prisons in England and Wales. It was interested in temporality, in how these experiences impacted staff and their practice contemporaneously and over time, as well as how accumulation of such experiences affected them. It explored how healthcare staff may still deliver quality healthcare to those who are suicidal and self-harming, even in the context of ongoing prison crises.

This thesis used processual ontology which conceptualises the world as dynamic, emergent, contingent, giving 'full reality to relations and becoming' (Renault, 2016: 22) and a congruent interpretivist epistemology. To further understand the complexities and nuances of healthcare staff responses to prisoner suicide and self-harm as posed by the research questions, a qualitative method was chosen. Qualitative methods 'are dynamic and capture emergent meanings' (Bosk, 2014), demonstrating their compatibility, feasibility and usefulness within the ontological approach adopted and as a fitting method for the methodology. 28 semi-structured interviews were undertaken, with three cohorts of participants: former prison healthcare staff, special knowledge stakeholders and senior managers. Data were analysed using reflexive thematic analysis, findings and analysis from which are reported herein.

Participants in this study repeatedly returned to the constrained context – custodial, under funded, under resourced – in which their work with prisoner suicide and self-harm occurred and the implications of this for them, their practice and the prisoners in their care. Prison healthcare staff experiences of self-harm and suicide are not only determined by clinical, psychosocial and environmental factors (Favril *et al.,* 2020), they are also profoundly influenced by governmental factors, the practical outworkings of policy decisions. The pressures, paucity and fast pace of work with those who are suicidal and self-harming are some examples of this, which can lead to disenfranchised trauma in staff. Staff experiences highlighted the need for broader definitions of self-harm to include invited violence. Staff experienced enduring effects from prisoner suicide attempts, even when life was preserved. Staff could experience distress and moral injury as they struggled to preserve prisoner dignity after death. Staff attested to the potential preventability of many suicides, including problems

of enacting Assessment, Care in Custody and Teamwork (ACCT) processes and constrained professional curiosity, causing frustration and despair in staff. This thesis argues that some prison suicides could be better understood as another example of Aitchison's (2024) induced self-violence, nomenclature that renders contributory factors more visible.

Prison healthcare staff acclimatised to working with prisoner self-harm and suicide. This is conceptualised as a dynamic continuum: from strategies that retain the human-ness of staff at one end, through the more prevalent phenomena of normalisation, detachment, desensitisation and dehumanisation. Dehumanisation is a finding for prison staff here and provided examples of the theory of malignant alienation (Morgan and Priest, 1984), in prison healthcare staff practice. Attending coroners' courts after suicides created significant stress, distress and anxiety for staff. These were further compounded by delays, the jury's poor understanding of prisons, and adversarial, blame-seeking inquests that responsibilised individual staff, deflecting inquiry from structural or governmental factors. Staff experienced inquests as damaging – before, during and after – creating enduring anxious, avoidant practice and staff attrition, resulting in poorer care for suicidal and self-harming prisoners. In amongst these findings, there was a cohort of prison healthcare staff whose strategies sustained them in an exceptionally tough workplace, enabling them to deliver compassionate healthcare to prisoners who self-harmed and/or were suicidal, at least *some* of the time. Staff were squeezed, yet still sentient and sustained by finding their work meaningful, by taking action to improve other health outcomes, collegial trusting, and talking and being witnessed.

This thesis aims in some small way to erode the hermeneutical marginalisation of prison healthcare staff experiences, assisting in making visible their experiences and those of prisoners who are suicidal and self-harming, thereby expanding prison epistemology. It rejects responsibilisation and espouses the interconnectedness of all people and things, as such it understands the reduction of prisoner suicide and self-harm, and enhancing prison safety as a collective endeavour. Although this thesis is about subjects more usually correlated with despair and not hope and incorporates some concerning findings – it contains pockets of hope. People, their thoughts and actions, can and do change. Because in amongst the sadness, despair and multiple poor decisions that have led to the prisons permacrisis, there are still people working with compassion and hope, demonstrating another way *is* possible.

Dedication

For…

Kim Lawson (1956 – 2022)

Who constantly supported me and believed I could do anything, even a PhD with preschool children in a pandemic.

Michael Lilley (1976 – 2024) and **Harry** (2014 – 2021)

Who always lived life to the full and were excited by its possibilities.

Acknowledgements

Firstly, I am profoundly grateful to my extraordinary supervisory team and to the University of Nottingham for funding this thesis. The skill, knowledge and empathy of Prof. Philippa Tomczak and Dr Mel Jordan is truly remarkable. It has been a privilege to have this process stewarded by such smart, creative, strong women. There have been many occasions where you have gone beyond what might reasonably be expected and I deeply admire the collegial and generous way you go about your work. Thank you for your patience, thoughtfulness and persistence with this work and with me.

Thank you to Prof. Annie Bartlett and the NHSE Strategic Clinical Network for Health in Justice and Other Vulnerable Adults, for establishing my interest in the impacts of prison work on the healthcare workforce and setting me off on this voyage of discovery.

Thank you to the PGR cohort in the School of Sociology and Social Policy at the University of Nottingham. Thank you to Dr Betta Zontini, Prof. Steve Farrall and Prof. Andrew Yip for your compassion and generosity as Directors of PGR study. Particular thanks to fellow travellers Katy, Amy and Moldir: your intellect, kindness and bravery always inspires me; I have learnt so much from you.

Thank you to Team UKRI – Gill, Cathie, Rebecca, Ruth, Alex, plus Tom – for your generous encouragement of the nascent ideas and for your wit and wisdom on this journey. Deeply grateful for each one of you – you have helped me more than I can say. To Dr Signy Henderson and Prof. Caoimhe McAvinchey, for being the midwives to my disparate ideas, helping me marshall them and encouraging me that I might (eventually) undertake a PhD.

Huge thanks to all the participants for your time and for sharing your experiences and their impacts with me. Thank you too to the inspirational individuals I met on my own prison work journey, especially to Celia, Bevali, Jackie, Saul, Jo, Caryn, Mandy, Tony and Paula. I learned so much from your love for and belief in people.

Starting a PhD in a new discipline in a pandemic with one year old twins means there are many, *many* people to thank. There are so many generous people that have enabled the team endeavour of this work, but I must specifically thank Jade, Jenny and my parents – Margaret and Jeremy, for looking after the dynamic duo whilst I was upstairs exploring these stories of prison death and hope.

Thank you to my friends and comrades at the council who were understanding, supportive and even covered aspects of my role, to help me focus on this thesis. Particular thanks to Paul, Una, Kaya and Fin.

Thank you to the wider of circle of family and friends, who enabled this PhD – those glorious folk are too numerous to individually name; they include GSA and BAPA. Special, special thanks to the Squad – Amy, Ashley, Cat and Jen – for your love and relentless cheerleading. To Hardie – Anna-Joy, David, Helen, Jessie, Matt, Mike, Sarah, Shona, Suzy – for your love and prayers. To Katherine, Ruth, Ruth, Grace, Anne, Alexandra, Kelly, Rach, Purna – your persistent kindness, encouragement and support made this possible. To my brother Jon and cousinsista Louise – thanks for being there always, your love sustains me in the crazy.

Thank you to Farah, Hannah, Sarah, Poppy, Varia, Amanda for making sure my commas were in the right place and for being the kind of friends I could be vulnerable enough to share my work with.

And finally, the biggest thank you must go to the beautiful boys that have sustained me through all this. Mik, you have the patience of a saint and have been unfaltering in your support of me as I became a student again. I could not have done this without you. To Isaac and Inigo, your boisterous enthusiasm for life and constant curiosity have made it easy for me to keep believing that mercies are new every morning and all things can keep being made new.

Contents

Setting the scene

Abstract

Dedication

Acknowledgements

Contents

Chapter 1: Introduction

1a) Aims

1b) Research questions

1c) Context of and rationale for the research questions
1c.i) Prisons
1c.ii) Prisons under austerity
1c.iii)Prison healthcare
1c.iv) Prisoner health, including self-harm and suicide
1c.v) Prison staff

1d) Core concepts
1d.i) Temporality
1d.ii) Responsibilisation

1e) Thesis structure

Chapter 2: Literature review

2a) Introduction
2a.i) Scope, methodology and structure of review
2a.ii) The importance of prison staff in reducing and preventing self-harm and suicide
2a.iii) Prison staff and prison occupational culture

2b) Narrative review

2b.i) Prison staff experiences of and perspectives on prisoner self-harm
2b.i.i) Prison staff responses to self-harm influenced by prison environment
2b.i.ii) Interdisciplinary conflict and role conflict
2b.i.iii) Staff perceptions of prisoners' self-harm: "genuine" and "non-genuine"

2b.i.iv) Impacts on staff behaviour due to perceptions of self-harm
2b.i.v) Impacts on staff of exposure to self-harm
2b.i.vi) Staff training and support

2b.ii) Prisoner suicide scholarship that includes prison staff perspectives
2b.ii.i) Staff responses: immediate responses and processing
2b.ii.ii) The impacts of prisoner suicide on staff perceptions and behaviours
2b.ii.iii) Long-term and profound mental health and wellbeing effects
2b.ii.iv) Support for staff
2b.ii.v) Potential protective factors

2b.iii) Parallel settings scholarship about staff encounters with self-harm at work
2b.iii.i) Attitudes towards self-harm
2b.iii.ii) Emotional and psychological impacts
2b.iii.iii) Training and support.

2b.iv) Parallel settings scholarship about staff encounters suicide at work
2b.iv.i) Emotional and psychological impacts
2b.iv.ii) Impacts on professional practice
2b.iv.iii) Cumulative impacts
2b.iv.iv) Staff support.

2c) Key concepts

2c.i) Occupational prison officer stress
2c.ii) Trauma in prison staff (disenfranchised trauma)
2c.iii) Moral injury
2c.iv) Normalisation of prisoner suicide and self-harm
2c.v) Desensitisation of prison staff
2c.vi) Malignant alienation
2c.vii) Coroners' courts and staff experiences

Chapter 3: Research design and practice

3a) Introduction

3b) Ontology

3c) Epistemology (including researcher positionality)

3d) Research planning:
3d.i) Research questions
3d.ii) Choice of research method
3d.iii) Changes to research design because of the Covid-19 pandemic
3d.iv) Research design

3d.v) Discerning, applying for and receiving ethical approval

3e) Data collection:
3e.i) Recruitment and final sample
3e.ii) The interviews (including: conducting sensitive interviews remotely)
3e.iii) Recording and transcription

3f) Data analysis:
3f.i) Analytic method: thematic, iterative
3f.ii) Analysing data together
3f.iii) Organising data for analysis

3g) Limitations: including nature of data and sample set

3h) Presentation of data and terminology used

Chapter 4: Staff experiences of working with prisoner self-harm: pressure, paucity and pace

Introduction

4a) Prisoner self-harm in an overloaded system
4a.i) Prisoner self-harm in an overloaded system: increasing, severe and different
4a.ii) Prisoner self-harm in an overloaded system: under-reported
4a.iii) Prisoner self-harm in an overloaded system: wider definitions required, including invited violence

4b) Layers of complexity: ethos, practices and prison itself
4b.i) Ethos and practice: custody over care, the unavailability of resources, poor information sharing
4b.ii) Environmental and governmental contributory factors: prison staff cultures and the "inevitability" of self-harm'?

4c) Experiencing self-harm as one demand amongst many: pressure, paucity and pace
4c.i) Greater complexity creates pressure
4c.ii) Paucity of healthcare staff = paucity of care
4c.iii) Faster pace contributes to iatrogenic harms and moral injury

4d) Unacknowledged trauma over time becomes disenfranchised trauma
4d.i) Unacknowledged trauma: denial
4d.ii) Disenfranchised trauma: acuity, chronicity, lack of resources

Conclusion

Chapter 5: Prisoner suicides: exploring healthcare staff experiences and enduring impacts

Introduction

5a) Prisoner suicides: healthcare staff experiences
5a.i) Methods and "the more violent, the more upsetting"
5a.ii) Staff initial responses: awful, sadness, guilt
5a.iii) Staff ~~"keep calm and~~ carry on", despite distress
5a.iv) Enduring distress after life-saving interventions

5b) Diminished dignity - enduring impacts
5b.i) Compromised corporeal dignity after death exacerbates distress
5b.ii) Communication about prisoner deaths

5c) Suicides were potentially preventable
5c.i) Presence of known risk factors (prisoner transfers) engenders staff despair
5c.ii) Inadequate policies and procedures – Assessment, Care in Custody and Teamwork (ACCT) failure
5c.iii) Governmental factors constrain professional curiosity
5c.iv) Staff experience suicides as preventable

Conclusion

Chapter 6: Acclimatising to dehumanising?

Introduction

6a) Acclimatisation: the accessibility and ease of normalisation
6a.i) Acclimatisation: adjusting to prison healthcare
6a.ii) Normalisation: an accessible coping strategy

6b) Acclimatisation: detachment
6b.i) Temporary detachment: aiding good practice?
6b.ii) Chronic detachment
6b.iii) Acute detachment

6c) Desensitisation
6c.i) Desensitisation: a consequence of chronic coping
6c.ii) Desensitisation in practice: less responsive and complacent
6c.iii) Desensitisation in practice: malignant alienation

6d) Prison healthcare staff become dehumanised
6d.i) Organisational dehumanisation

6d.ii) Mechanistic dehumanisation
6d.iii) Perception and treatment of staff – human or units of productivity?
6d.iv) Dehumanisation: insidious

Conclusion

Chapter 7: Coroners' courts: distress, delay, deflection and damage

Introduction

7a) Coroner's court appearances
7a.i) Stress, distress and anxiety
7a.ii) Preparation, support and mitigation

7b) Compounding stressors contribute to harms
7b.i) Delay - extended waits
7b.ii) Difficulty - poor public/jury comprehension of prison
7b.iii) Deflection - combative blame cultures obscure governmental factors

7c) Damaging consequences for practice and beyond
7c.i) Damaging consequences for practice: anxiety and avoidant practice
7c.ii) Further damaging consequences: risk and retention

Conclusion

Chapter 8: Pockets of Hope

Introduction

8a) Squeezed, yet still sentient staff
8a.i) Staff under pressure but capable of feelings
8a.ii) Colleagues important in retaining emotional connection

8b) Finding meaning in work

8c) Taking action: avenues for improved outcomes
8c.i) Avenue one: healthcare interventions with measurable good outcomes
8c.ii) Avenue two: involvement with strategic decision-making

8d) Collegial trusting
8d.i) Frontline experiences of collegial trusting
8d.ii) Fostering collegial trusting: time

8e) Talking and being witnessed
8e.i) Why witnessing matters

8e.ii) Modes of witnessing
8e.iii) Challenges to witnessing

Conclusion

Chapter 9: Conclusions

Introduction

9a) Chapter findings and analysis
9a.i) Chapter 4 findings and analysis
9a.ii) Chapter 5 findings and analysis
9a.iii) Chapter 6 findings and analysis
9a.iv) Chapter 7 findings and analysis
9a.v) Chapter 8 findings and analysis

9b) To notice, to make visible: expanding prison epistemology

9c) Achieving safer prisons?
9c.i) A collective task
9c.ii) Investment in prevention

References

Appendices:

1. Participant characteristics
2. Interview schedules
3. Researcher reflection questions
4. Participant Information Sheet
5. Participant consent and GDPR form
6. Participant distress protocol

Chapter 1: Introduction

1a) Aims

The aim of this thesis is to better understand prison healthcare staff experiences of prisoner suicides and self-harm, and how this affects them, their practice and the prisoners in their care; ultimately, hoping to contribute to the alleviation of prisoner suicide and self-harm. It pertains to staff in the jurisdiction of England and Wales and includes a broad definition of healthcare staff, e.g. administrators, psychologists, nurses. It is not just concerned with the impacts on staff at the time of these events, but curious as to how staff may continue to experience the impacts over time and, how an accumulation of such experiences may affect them. It is also interested in how healthcare staff may still deliver quality healthcare to those who are suicidal and self-harming, even in the context of a prison permacrisis; and the ongoing possibilities for better ways of being and doing.

1b) Research questions

Chapter 3 contains a discussion about the development of the study's research questions but to aid the reader from the outset, they are included here. The primary research question is:

What are the impacts of encountering prisoner suicide and self-harm on prison healthcare staff?

This is deepened by three secondary research questions, that distinguish between contemporaneous impacts on staff and those experienced over time, as well as considering the implications of these impacts for prisoners in their care. These secondary questions are:

a) *What are the initial narrated impacts of encountering prisoner suicide, self-harm and/or repeated self-harm on prison healthcare staff?*
b) *What are the enduring narrated impacts of encountering prisoner suicide, self-harm and/or repeated self-harm on prison healthcare staff?*

c) *What are the impacts of cumulative exposure on prison healthcare staff, including on their responses to prisoner self-harm and suicide attempts?*

This chapter will now briefly discuss 21st century prisons, prison healthcare, prisoner health and prison staff in England and Wales, to contextualise the study and illuminate the rationale behind the research questions.

1c) Context of and rationale for the research questions

This introduction briefly sketches the prison landscape to aid the reader. Firstly, it provides an overview of prisons in England and Wales in the early 21st century, including the effects of austerity policies since 2010 and the contingent depth of difficulties within prisons. It then considers prison healthcare within these institutions and prisoner health, including the high rates of suicide and self-harm. It concludes with a summary on prison staff: who prison healthcare staff comprise, why they are germane to reducing prisoner suicide and self-harm and problems with recruitment and retention. The context is important for understanding the research questions, as well as the data herein, particularly in a thesis that argues against ascribing responsibility for suicide or self-harm to one person, conceptualising its contingencies. Grasping the importance of context, the 'practical and organisational factors' for prisoner suicide (Liebling, 1992: 226), mental health (Jordan, 2012) and self-harm (Groves, 2004) is not new, but it is still crucial. An acquaintance with the varied prison milieu is therefore required to begin to examine what happens when prison healthcare staff encounter prisoner suicide and self-harm, what happens next and why.

1c.i) Prisons

The prison system in England and Wales contains 122 prisons: 105 are run by His Majesty's Prisons and Probation Service – and 17 are run by private contractors such as Serco (HMPPS, 2024a). Some prisons were built in the early Victorian era, others are newly constructed. They hold between 160 and 1600 people, with the male estate having four categories of prison (A-D) and women being held together: women account for around 4% of the prison population (HMPPS, 2024a). Within these prisons, people from the Global Majority are over-represented,

comprising 27% of the prison population, as compared with 18% of the general population (HMPPS and Ministry of Justice, 2024). Extensive literature highlights poor prisoner health (Davies *et al.,* 2020; Fazel and Baillargeon, 2011; McLeod *et al.,* 2020; Stürup-Toft *et al.,* 2018). This is discussed in more detail in the next section, 1c.iii. Prison populations have quadrupled since the early 1900s, doubling between 1992 and 2012, though 'carceral expansion is not a destiny, but a policy', crucially meaning such expansion is a process that can be 'questioned, slowed down and eventually, reversed' (Wacquant, 2009a: 5). Prison sentences have been increasing since the 1990s and as of March 2024 there were approximately 134 prisoners per 100,000 of the population in England and Wales (Sturge 2024: 5). The jurisdiction also has the highest imprisonment rate in Western Europe (Fair and Walmsley, 2021). 60% of prisons are categorised as overcrowded (Sturge, 2024), with the worst prisons running at over 170% of their operational capacity (The Howard League, 2024). Still, the prison population is predicted to rise to 95,100 and 114,200 by November 2027 (Ministry of Justice and Office of National Statistics, 2024). Within these poor conditions, prisons are not homogenous. There is significant variation 'in their moral and relational climates' with empirical research demonstrating that 'some prisons are more survivable than others' - that there are literally less people dying by suicide (Liebling, 2011: 532). A 2024 paper using Liebling and colleagues *Measuring the Quality of Prison Life* (MQPL) framework found wide variations across prisons persisted, ranging from 'high' performance to 'very poor', the differences being 'qualitatively distinct' (Auty and Liebling, 2024: 748). This significant variation between institutions effects how prisoners experience imprisonment, creating demonstrably different outcomes for individuals and institutions.

Prisons are still, as noted by the Justice Select Committee Chair in 2017, 'in a very much ongoing state of crisis' (Politics Home, 2017). This crisis has not since abated, with commentators adopted the term 'permacrisis' to describe prisons, permacrisis being a 'continuous cycle of crises that have become deeply ingrained' which cause 'prolonged instability, insecurity and upheaval' (Papadopoulou *et al.,* 2024). The most recent annual report for HM Inspectorate of Prisons (2023) noted 'living conditions in reception prisons remained a serious cause of concern', that 'Many establishments were overcrowded', with prisoners 'locked in their cells for unacceptably long periods of time'. Without suggesting that prisons in England and Wales prior to 2010 were rehabilitative utopias, there have been

measurable declines in prisons, in their quality and safety, catalysed by austerity policies since 2010.

1c.ii) Prisons under austerity

When the Conservative and Liberal Democrat coalition government came to power in May 2010 it devised a range of public sector spending cuts, arguing it was an economic necessity following the financial crash of 2008: austerity. However, the economy in 2010 was stable, with low debt by historic standards; indeed, the emergency 2010 budget 'was mainly political rather than economic in its conception and presentation', a primary example of 'statecraft' - an attempt to redefine the 'terms of the debate on economic policy' (Gamble, 2015: 47). Austerity created a 'regressive distributional effect', particularly effective those who relied on public services, with studies showing 'the clash between efficiency, effectiveness, and equity' resulting in 'the deepening of poverty and inequality' (Ismail, 2019b: 2). In the Ministry of Justice, the budget of HMPPS was reduced by 22%: £3.47 billion in 2010/2011 to £2.71 billion in 2016/17, achieved through the sale of assets (prisons) and the Benchmarking policy programme (Ismail, 2020b). Benchmarking 'consolidated pay structures for management and operational staff, along with early retirement offers, redundancy, fixed-term contracts for the existing workforce, and the introduction of new pay levels in line with market rates, which were often lower than existing staff salaries', thereby reducing frontline officer numbers by 30%, all without a reduction in prison population (Ismail, 2019b: 2). Following these staff cuts, the prison population continued to rise, meaning 'operational safety had been compromised in part due to low staffing levels or inadequate deployment of staff on wings', giving rise to recommendations that 'staff are never alone on a wing and the allocated budget does not impact the core operational safety of a prison' (CoE CPT, 2017: 10). Despite very high levels of documented serious violence, it was under-reported, and the 'cumulative effect of certain systemic failings was that none of the establishments visited could be considered safe for prisoners or staff' (CoE CPT, 2017: 9). Prior to the 2020 Covid-19 pandemic, prisons were singled out amongst public services as exceptional for how markedly their quality has declined due to austerity (Institute for Government, 2018); in their most recent report, prisons were termed as 'particularly dire' (Institute for Government, 2023: 8). The authors of the MQPL framework cite the correlation between the 'material resources of prisons and their moral

quality', noting that 'low resource prisons tend to squeeze out order, humanity, and personal development' (Liebling, 2019: 193). Less well resourced prisons are less safe.

The final drafts of this thesis were being prepared in summer 2024, a time when the crisis of overcrowding in prisons meant the newly elected Labour government had to take emergency legislative steps to address it. It is not known at this time what impacts the emergency legislation may have on the exponential growth of the prison population. In August 2024, there was the highest number of prisoners recorded in England and Wales at 88,350; leaving an estimated operational capacity in the male estate of around 100 spaces (Ministry of Justice, 2024c). Prisons are notably overcrowded in an overloaded justice system, struggling in every part. For example, the Metropolitan police were found to be institutionally racist, misogynistic and homophobic (Casey, 2023), delays in crown courts are 'causing significant injustice' (House of Commons Justice Committee, 2022: 3) and the difficulties faced by a reuniting probation service with high profile failures with devastating consequences. As Liebling soberingly notes, 'I have carried out research in prisons for 35 years… The current period is the most unstable and ineffective I have observed' (Liebling, 2023). This is set within the wider context of other interconnected social infrastructure crises, e.g. the semi-functional NHS and an ongoing housing crisis, symbolising the ongoing trajectory from social state to penal state, that 'penalize social marginality' (Wacquant, 2009a: 3). And 'while parallels can be drawn' to analogous policy areas, the justice system 'appears to generate crises of a particular type, intensity and frequency' (Annison and Guiney, 2023: 6). Prisons become the receptacle for myriad societal problems, overloaded with people who would be better served by interventions congruent with their primary need, e.g. trauma-informed women's services, drug rehabilitation or mental health provision. The provision of healthcare in prisons will now be examined.

1c.iii) Prison healthcare

Prison healthcare commissioning is complex and has changed significantly over the last two decades. It is based on a principle of equivalence, that is prisoners 'are afforded provision of and access to appropriate services or treatment… and that this is considered to be at least consistent in range and quality… with that available to the wider community to achieve health equity and to reduce health inequalities' (HM Government and NHSE, 2019: 2). Since 2006

healthcare has been provided by the NHS, then after the Health and Social Care Act 2012, was commissioned by ten Health in Justice teams within NHSE (Davies *et al.*, 2020), except for emergency care, ambulance services and out-of-hours services (NHSE, 2022). These NHS commissioned contracts typically lasted five years and include the provision of 'primary care, mental health, dentistry, ophthalmology, public health functions, sexual health and substance misuse' (Edge *et al.*, 2022: 109). This multi-layered commissioning context involves state, private and voluntary sector partners, usually from offices outside the prisons and continues to evolve with the advent of the Health and Care Act, 2022 and the creation of Integrated Care Systems (ICS). Nationwide, 42 ICS's will now include prison healthcare commissioning within their remit and, although still overseen regionally by Health and Justice commissioners, details are scant and evolving, and there are concerns about a loss of expertise through the new arrangements (Edge *et al.*, 2022). There is a recruitment and retention crisis throughout the NHS (The King's Fund, 2024), prison healthcare is not exempt from this. The HM Inspectorate of Prisons noted a concern that 'a lack of staff or an over-reliance on agency workers is leading to reductions in service', acknowledging 'Health services are often kept going by small, dedicated teams of professionals, but there is an emerging fragility… this year' (HM Inspectorate of Prisons, 2023: 7). Although NHS funding was maintained during the explicit austerity programme of the coalition government from 2010, it plateaued, even as the general population grew and in prisons there was an increase in complexity and need; meaning funding was decreased in real terms (Ismail, 2023). Underinvestment across healthcare in prisons and community settings has consequences and 'austerity compounds' the problems created by the already stretched resources of prison healthcare (Ismail, 2023: 104). Additionally to structural issues such as 'overcrowding and understaffing', frequent movement and short sentences constrain the 'optimal delivery of care' (Favril et al., 2024: 257). This happens in a setting with a fundamentally different ethos from other healthcare provision (MacDonald, 2018; Williams *et al.,* 2018). Prisoners experience high levels of poor mental and physical health (Favril *et al.,*2024). Thus adding another layer to the structural, operational and ethos challenges, with the complexities and co-morbidities of prisoner health - including prisoner suicide and self-harm.

1c.iv) Prisoner health, including prisoner suicide and self-harm

Background

Prisoners have a high burden of physical and mental health care needs and poor health outcomes (McLeod *et al.,* 2020). They have elevated imported health needs (Favril *et al.,* 2024; Fazel and Baillargeon, 2011; Plugge *et al.,* 2017); multiple pathologies, poorer vaccine coverage, poorer access to treatment and prevention programmes (O'Moore, 2016) and face significant inequalities in access to healthcare before, during and after incarceration (Davies *et al.,* 2020; Plugge *et al.,* 2017). They are disproportionately affected by the social determinants of health (Fazel and Baillargeon, 2011; McLeod *et al.,* 2020), because 'health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources' (Marmot, 2020: 5). Many people in prison 'do not access primary care in the community', so imprisonment can present an 'opportunity to assess, diagnose and treat health needs' (Favril et al., 2024: 249). Therefore, prisons must be included in broader public health strategies to help address these disparities and in acknowledgement of prisons being part of wider society (Kinner and Wang, 2014; Lee *et al.,* 2015; Wildeman and Wang, 2017): what happens inside prisons matters for communities too. Prison overcrowding has adverse effects on prison health and safety (Hough *et al.,* 2008; MacDonald, 2018), leading to unsanitary and violent conditions (Penal Reform International, 2018; UNODC and WHO, 2013). The poor physical environment has an impact on prisoners and staff (Auty and Liebling, 2020; Jewkes *et al.,* 2019, Jordan, 2011; Perrett *et al*., 2019). Ageing buildings inappropriately designed for modern imprisonment (Jewkes *et al.,* 2019) and poor material conditions due to a lack of cleaning or maintenance, can considerably affect how prisoners behave and lead to conflict and assault (McGuire, 2018). 64% of prison nurses in a 2017 RCN Safe Staff survey said the quality of the care given on their last shift had been compromised. Prisoner (ill)health is contingent on staffing levels, overcrowding and physical environments.

Prisoner suicide and self-harm

Part of this prisoner health – and safety – picture, are prisoner suicide and self-harm. For context, overall suicides rates in England and Wales have declined overall by 21% since 1981, but have slightly risen each year since 2018; men are three times more likely than women to die by suicide (ONS, 2024). The highest rates of suicide are for those aged 45-54; the most deprived 10% of areas in England had a suicide rate 14.1 per 100,000, almost double the rate - 7.4 - in the least deprived 10% (Kirk-Wade, 2025: 14). Suicides and self-harm occur at an

elevated rate in prisons when compared to community cohorts, with one oft-cited study suggesting suicide rates are five to six times for men and 20 times higher for women in prison, than in the general population (Fazel *et al.,* 2011). However, these comparisons overlook factors prevalent in prison population demography, such as living in deprived areas prior to imprisonment and the ageing prison population, as cited earlier in this paragraph. When considered along with, for example, the data on deprivation, suicide rates for men in prison may be two to three times that of their community counterparts; still an elevated rate, still situated in inequalities. Along with demographic factors, criminological, clinical, and institutional risk factors are associated with prison suicides (Zhong et al., 2021: e172). Recent years have seen some of the highest recorded levels of prisoner suicide and self-harm (Ministry of Justice, 2025). This has happened in the context of austerity which led to significant declines in prison order so that 'levels of disorder and suicide returned to or exceeded' those of the 1980s (Auty and Liebling, 2024: 730). Austerity policies have negatively impacted prisoner and staff health, whilst 'the persistence of austerity normalises the increasing levels of suicide and violence' (Ismail, 2019b: 9). As the Benchmarking programme began to be rolled out, the levels of violence, self-harm and suicide began to rise year on year from 2013 until 2016, which saw 354 deaths in custody, 124 of which were suicides, the highest number on record (Ministry of Justice, 2025).

Since 2016, the annual number of deaths in custody has only once been below 300, though suicide numbers lessened initially, suicides have increased in the last two years and rates remain at around 1 in 1000 prisoners (Ministry of Justice, 2025). For self-harm, the most recent annual figures show that in the year to December 2023, there were 829 incidents per 1,000 prisoners, totalling 70,875 incidents with 12,914 individuals recorded as self-harming, representing a 20% rise (Ministry of Justice, 2024a). The number of people dying by suicide in prison for the year ending 2023 was 96. These high rates of prisoner suicide and self-harm demonstrate that although prisoners from communities with higher prevalence of suicides are over-represented, death and self-harm are increasingly part of the experience of imprisonment. As noted earlier in this section, empirical research demonstrates that some prisons are literally more survivable than others (Liebling, 2011). Clusters of suicides and Urgent Notifications have become part of the prison landscape. For example, an inspection at HMP Nottingham in 2017 triggered the issuing of an Urgent Notification from the Chief

Inspector of Prisons to the Secretary of State, in part due to the eight suicides that had occurred there since the previous inspection in 2016 (HMIP, 2018). These higher rates of prisoner suicide and self-harm have implications for those living and working there (Ludlow *et al.,* 2015; Marzano *et al.,* 2013; Slade *et al.,* 2019). As such, this is an urgent and pertinent area for academic research.

Prisoner "natural cause" deaths

Alongside the rise in suicides, there has been an increase in deaths categorised as "natural cause" deaths (Ministry of Justice, 2024a). These are defined as 'any death of a person as a result of a naturally occurring disease process' (Ministry of Justice, 2020: 9) as opposed to suicides, homicides or other non-natural – usually drug related – deaths. The problematic nature of the frequency and normalcy of deaths in prisons are often 'widely overlooked' (Gagglioli and Elger, 2017: 38). "Natural cause" deaths have increased over the last 20 years: for example, there were 86 in 2003 or 2.5 per 1000 prisoners, to 188 in 2023 or 3.6 per 1000 prisoners. This is for a variety of reasons including sentence inflation, historic abuse cases and therefore an ageing and chronically sick prison population, needing more palliative and end-of-life care (Roulston *et al.,* 2020: 225). However, not all such deaths are due to the ageing population, 39% of deaths were of those aged 35 – 54 and both the PPO and Coroners have found some "natural cause" deaths to be preventable (IAPDC and RCN, 2020). The same report noted, 'for most prisoners the combination of poor diet, psychological stress and inactivity results in their leaving prison in a dangerously degraded physical and mental condition' (IAPDC and RCN, 2020: 7). Whether the cumulative effects of poor nutrition and a lack exercise hasten death or whether crucial delays to ambulances or poor administration of resuscitation fail to prevent death following cardiac arrest, the conditions of custody can adversely impact "natural cause" deaths. Whilst not the focus of this study, it is worth noting the obfuscating misnomer of "natural cause" deaths, as well as the increase in their frequency and therefore normalcy in the prison estate.

1c.v) Prison staff

There is a broader field of study concerning officer staff and their workplace experiences that this thesis draws on, this is more closely examined in chapter 2 – literature review. Officer staff are the most researched prison staff cohort – individually and collectively. Prison staff cultures

are dynamic, influenced by a variety of factors including the locality's employment opportunities, previous events at the prison and the undergirding ethos of it (Sparks *et al.,* 1996). These cultures can 'vary considerably' with 'significant consequences' for prisoner quality of life (Crewe *et al.,* 2011: 94). There are official numerical data about how many, at what grade and attrition, are published quarterly and are publicly available via HM Prisons and Probation Service website (HMPPS, 2024b). No such data is published on prison healthcare staff so numbers, across multiple providers and complex commissioning, are harder to ascertain, given the complexity of the commissioning arrangements across multiple providers. Prison healthcare staff cohorts include but are not limited to: nurses (registered general nurses, mental health nurses, learning disability nurses, substance misuse nurses), doctors, psychologists, psychiatrists, psychotherapists, counsellors, administrators, dentists and pharmacists. Prison healthcare staff and their experiences of prisoner self-harm, suicide and attempted suicide have received very limited scholarly attention (Jewkes *et al*., 2019; Roulston *et al*., 2020). This thesis helps to address this gap.

Austerity and prison staff – recruitment and retention

Historically, scholars noted private prisons' staff 'low numbers, inexperience and lack of confidence' which enabled more 'bullying, assaults and other problems linked to a general lack of "jailcraft" ', with managers admitting running prisons with so few staff was 'challenging' (Crewe et al., 2011: 95 and 106). Understaffing left staff feeling 'a sense of powerlessness and vulnerability' (Shefer and Liebling, 2008: 267). As previously noted, Benchmarking policies from 2013 reduced staff by about 30%, creating the largest reduction in prison staff numbers, around 30% of staff, prisons in England and Wales have ever experienced (Peacock *et al*., 2018). Crucially it also meant a substantial reduction in experienced staff, as some with long-serving careers took voluntary redundancy, offered as part of the Benchmarking process. This created increases in violence, suicide and self-harm before recruitment efforts were made to bolster officer numbers somewhat; however, the loss of experienced officer staff was irreversible (Ismail, 2023). The gap left by those experienced staff remains and staff retention is poor: almost half of Band 3-5 officers leaving have been in role two years or less (HMPPS, 2024b). There has never been a lower proportion of prison officers with more than ten years' experience (Institute for Government, 2023). The challenge of recruiting to prison roles, particularly in some geographies as identified in Shaw's 2017 review into deaths at HMP

Woodhill, persist. The impacts of this reduction in officer staff on healthcare staff continues, a 2020 study found three quarters of missed prison healthcare appointments, were partly attributable to a lack of officer staff to escort prisoners to their healthcare appointments (Davies *et al.,* 2020). Within prisons, healthcare staff are crucial yet under-researched (Plugge *et al*., 2017). As well as a recruitment and retention problems across all prison staff groups, there is a recruitment and retention crisis throughout the NHS (The King's Fund, 2024). Unsurprisingly, prison healthcare is not exempt from this, adding to the complexity of prison healthcare and engendering a reactive, crisis-led model of care (Sheard *et al*., 2023). Lower staff numbers and frequent use of agency staff then stymied delivery (Ismail, 2019a). HM Inspectorate of Prisons noted a concern that 'a lack of staff or an over-reliance on agency workers is leading to reductions in service', acknowledging 'Health services are often kept going by small, dedicated teams of professionals, but there is an emerging fragility… this year' (HM Inspectorate of Prisons, 2023: 7). Although NHS funding was maintained during the explicit austerity programme of the coalition government from 2010, it plateaued, even as the general population grew and in prisons there was an increase in complexity and need; meaning funding was decreased in real terms (Ismail, 2023). Prison healthcare staff provide primary healthcare and mental health care, fulfil public health roles, e.g. sexual health, vaccination programmes, and work with all prisoners, in every part of the prison. They are crucial yet under-researched (Plugge *et al*., 2017). How prison healthcare staff work with and are affected by prisoners who are suicidal and self-harming is a research lacuna this thesis begins to address.

Prison staff and their relationships with prisoners are core to the reduction of suicide and self-harm (Liebling, 1998; Ludlow *et al*., 2015; Howard League, 2017). Research with prisoners who attempted suicide found that talking with staff is crucial in prevention (Marzano *et al*., 2016; Suto & Arnaut, 2010). This includes healthcare staff, who may be emergency first responders when resuscitation is needed or those who work with prisoners over longer periods such as a psychologist or substance misuse nurse. Prison staff are essential in the 'identification of risk and the provision of support [for prisoners], despite often feeling unqualified, untrained, or unskilled for this kind of work', and can receive limited care or support (Marzano *et al.,* 2013: 2). Prison work involves a tension between care and custody, irrespective of role (Liebling, 1992; Tait, 2008). For prison healthcare, the 'clash of underpinning philosophies of caring and

custody […] is one that cannot be underestimated' (Walsh, 2009: 143). Prison staff witness significantly more violence, self-harm and suicide than people in the general population (Bennett, Crewe and Wahidin, 2008). Prison staff are affected by their high levels of exposure to these events, impacting their perceptions, behaviours and practice (Marzano *et al.,* 2013; Smith *et al.,* 2019; Tomczak, 2018; Walker *et al.,* 2017). A better understanding of staff experiences may improve prisons (Liebling, 1992; 2011), because staff can prevent or exacerbate prisoner distress (Tait, 2008) and influence prison safety (Auty and Liebling, 2020; Liebling, 2011). This is further explored in the literature review, in section 2b. Prison healthcare staff are a crucial part of the prison ecology, therefore, greater understanding of how this work effects their attitudes and practice is helpful in supporting these staff and also, in the alleviation of prisoner suicide and self-harm.

1d) Core concepts

1d.i) Temporality

Time pervades the research questions and is pertinent in each chapter of the thesis. Whether that is through the prevalence of problematic *pace* for professional curiosity which makes easily accessible normalisation narratives attractive; the enforcing of prisons and coroners' courts rhythms onto healthcare staff *time*; the emphasis on managerial, not process, *time*; or the way healthcare staff described the eroding impacts of this work *over time.* Time is ever-present. Criminologists have considered time as a commodity that is 'linear and goal-oriented, measurable, accountable and definable in terms of monetary value' (Nellis, 2002: 64). Exploring the probation service within courts, Robinson noted the 'recalibration of a new temporal order' to achieve the 'court's desired pace' due to coercive isomorphism, that is the process of one organisation being pressurised by another on which it is dependent (Robinson, 2022: 214). Extending Robinson's contention, prison healthcare staff experience the coercive isomorphism of the prison system, reducing their temporal capital and expecting an ever-quickening pace. Experiences of prisoner suicide and self-harm were not always responded to immediately by staff, there could be temporal lags or unnoticed responses masquerading as temporal lags, partly attributable to 'anti-emotion expectation' present in wider healthcare staff cultures (Kasket, 2006: 143). A study with senior physicians in a hospital found reactions to patient deaths could 'remain buried for decades and still erupt suddenly in vivid memories' (Whitehead, 2012: 274). Where prison staff can remain 'enduringly connected' to prisoner

suicides (Barry, 2017: 53), these too may 'remain buried' and 'erupt' suddenly. As such this thesis explores not just the enduring nature of these experiences but also their cumulative nature, over time, for the healthcare staff with implications for prisoners in their care.

1d.ii) Responsibilisation

Neoliberalism

Since the 1970s, neoliberalism has replaced post-war social consensuses, emerging from political and economic thought and practice to become the 'hegemonic discourse of our times' (Reiner, 2007: 1-2). Wacquant maps neoliberalism as a 'transnational political project aiming to remake the nexus of market, state, and citizenship from above', with four 'institutional logics': economic deregulation, welfare state retraction, the trope of individual responsibility and 'an expansive, intrusive, and proactive penal apparatus' (Wacquant, 2009b: 306-7). The resultant shift in policy has 'decimated state welfare and increased punitiveness' across the public sector in England and Wales (Ismail, 2023: 27) and across "Western" countries has weakened holistic approaches to public policy (Raphael *et al,.* 2008). Within this, there has been enabled an eschewing of the wider causes or social determinants of crime whilst locating responsibility within a sole rational, agentic actor – the "criminal"/"prisoner", "the other". Some scholars have critiqued the broadbrush 'neoliberal penality thesis', highlighting a lack of consensus on *how precisely* neoliberalism intersects adversely with penal matters, and the significance or otherwise of that (Xenakis and Cheliotis, 2019). Mindful of this definitional looseness and contestation, to avoid the 'perils' of evoking neoliberalism 'as a catch-all term that sheds no further light on underpinning processes', when used without specificity, this thesis evokes it here briefly and contextually (Peacock *et al.,* 2018: 2). Neoliberalism is the context here firstly, for the austerity measures since 2010 (see 1c.ii), and secondly, for the atomising of responsibility, including for crime and for suicidality and for self-harm: responsibilisation.

Responsibilisation

'Neoliberal subjectivity[ies]' enable *responsibilisation*, that is the 'individualising of pain, suffering and resistance' (Peacock *et al.,* 2018: 14). Garland's (1996: 452) foundational prison sociology noted this 'responsibilization strategy'. Garland deploys this terminology with reference to national government acting through non-direct means, devolving 'responsibility

for crime prevention on to agencies, organizations and individuals which are quite outside the state and to persuade them to act appropriately' (Garland, 1996: 452). Workplace mental health literature attests to the 'focus on interventions directed towards individual workers and illnesses' as compared with the lack of 'interventions for improving working conditions and enhancing mental health' (Rugulies *et al.,* 2023: 1368): that is a broader conceptualisation of causality and accountability for illness, that then sets about addressing illness via that understanding. Prison scholars since Garland have noted this ongoing 'shift in rhetoric', belying a shift in focus from addressing physical and mental health concerns to 'physical violence and psychoactive drugs', which are 'regarded as undermining safety' (Scott, 2018: 26), individualising and pathologising phenomena that have social, environmental and governmental roots. Within this context, prisons and those within them become further demarcated, ostracised and even, dehumanised; contributing to the creation of prisons that reify responsibilisation of the individual for crime.

Responsibilisation is also found in attitudes towards suicidality and for self-harm, both in prison and community settings. Suicide too is often understood as 'individual rather than societal' which may lead 'to the fostering of unjust relations of responsibility for suicide prevention' that can be burdensome and harmful for those responsibilised, despite general acceptance 'that a range of social, cultural and political factors contribute to suicide' (Fitzpatrick, 2018: 180). Those who die by suicide whilst imprisoned are doubly stigmatised by this location of responsibility whilst paradoxically, being distanced from the locus of power, thereby limiting their agency. As too are their families and those who work with them. Responsibilisation is undesirable and ultimately, unfeasible. This thesis agrees that the '… web of social relations, the good of the individual is also intimately bound up in the good of others' (Raymen, 2022: 225). It also agrees that to reduce both suicide and self-harm in prisons requires 'a comprehensive approach that comprises multilevel interventions' (Favril *et al.,* 2020: 689), working across scales from the UN Special Rapporteur, to a prison reception nurse and beyond. Therefore, the location of responsibility for something – e.g. a criminal act, an act of self-harm, a suicide – cannot be understood to reside in an atomised individual person. This thesis relies on 'solidarity woven around the collective basics of everyday […] life' to provide 'inspiration for new ways of thinking (Manning, 2018: 19). This rejection of divisive narratives of neoliberal-responsibilistation are core ontologically and epistemologically for this

thesis, as well as for conceiving future possibilities to ameliorate high levels of prisoner suicide and self-harm and the harms these create for prisoners, their families and prison staff. The ontology and epistemology of the thesis is outlined more fully in chapter 3. Broader, dynamic, contingent conceptions of both self-harm and suicides could enable less harmful encounters with the justice system and prisons, whilst embracing the social determinants of suicide and self-harm and utilising these as levers for change.

1e) Thesis structure

This thesis has nine chapters. It begins with this introductory chapter, which précis the findings and introduces key background information about prisons, prison healthcare and how they come to be so in England and Wales in the early part of the 21st century. Chapter 2 is a literature review which summaries pertinent literature on prison staff engaging with suicidal and self-harming prisoners, as well as reviewing literature from other parallel workplaces, in which staff work with suicide and self-harm, e.g. paramedics. Chapter 3 details the theoretical underpinnings of the thesis, in terms of ontology and epistemology, before reporting on the process of research design, then the data collection and the analysis. It concludes with a note about the choice of nomenclature for prisoners, self-harm and suicide.

This is followed by four conventional findings and analysis chapters (4-7) and then a chapter entitled Pockets of Hope, which is included in keeping with the ontological position of the work and includes findings and analysis. Chapter 4 explores prison healthcare staff experiences of prisoner self-harm and argues for broader definitions of self-harm to include invited violence. It argues that prisoner self-harm is influenced by governmental factors; and not just clinical, psychosocial and environmental factors (Favril *et al.,* 2020). For example, the way prison healthcare staff can work with people who are suicidal and self-harming is significantly affected by the pressure, paucity and fast pace of the work. Therefore, staff can experience moral injury and disenfranchised trauma through this work. Chapter 5 outlines staff experiences of prisoner suicides, the wide range of prisoner suicide methods and even where lives are saved, staff may experience enduring distress from their involvement. Prisoners' dignity after death could be compromised, creating distress in staff and another further potential for moral injury. Prison suicides may be better understood as 'induced self-

violence' (Aitchison, 2024: 905). Staff reported the potential preventability of many suicides, including problems of enacting ACCT processes and constrained professional curiosity, causing frustration and despair in staff. In chapter 6 it is argued that prison healthcare staff acclimatise to working with prisoner self-harm and suicide. This is conceptualised here as a dynamic continuum: from strategies that retain the human-ness of staff at one end, through phenomena more prevalent in the data of normalisation, detachment, desensitisation and dehumanisation. Dehumanisation is a finding for prison staff here and data included examples of 'malignant alienation' (Morgan and Priest, 1984: 11). Chapter 7 concerns prison healthcare staff experiences of coroners' courts and the significant stress, distress and anxiety they evoked in staff. These feelings were further compounded by delays, the jury's poor understanding of prisons, and adversarial, blame-seeking inquests that responsibilised individual staff, deflecting inquiry from structural or governmental factors. Staff experienced inquests as damaging – before, during and after – creating enduring anxious, avoidant practice and staff attrition, resulting in poorer care for suicidal and self-harming prisoners.

Chapter 8, Pockets of Hope, is included to emphasise the hopeful, emergent nature of processual ontological approaches. Its findings pertain to the cohort of prison healthcare staff who negotiated an exceptionally tough workplace by using strategies and habits to sustain themselves within it and deliver compassionate healthcare to prisoners who self-harmed and/or were suicidal, at least *some* of the time. Staff expressed being squeezed, yet still sentient and sustained by finding their work meaningful, by taking action to improve other health outcomes, collegial trusting, and talking and being witnessed. Chapter 9 draws the thesis to its conclusion, summarising findings and considering the implications of the thesis for expanding prison epistemology and the collective task of achieving safer prisons.

In concluding this introduction, the reader is reminded that the findings chapters contain depictions of prisoner suicide and self-harm, which may be distressing. In the spirit of collectivism and to honour process time, please do take breaks from reading and/or connect with a person who gives you life, as needed whilst reading this work.

Chapter 2: Literature review

2a) Introduction

2a.i) Scope, methodology and structure of review

A narrative literature review was undertaken as the first phase of this study. Such reviews are 'an overview of a field of study through a reasonably comprehensive assessment and critical reading of the literature' (Bryman, 2012: 102), as appropriate to my interpretivist epistemology. This included: searching on databases, e.g. Google Scholar, hand searching bibliographies of articles and attention to relevant grey literature. The literature was then grouped in four cohorts to review, these were i) prisoner self-harm scholarship that includes prison staff perspectives; ii) prisoner suicide scholarship that includes prison staff perspectives; scholarship from parallel settings about staff encounters with iii) self-harm at work and iv) suicide at work. Literature on staff responses to self-harm and suicide in parallel workplaces enriches the scant information regarding healthcare staff responses in prison. Parallel settings include: secure psychiatric settings and acute mental health settings. Emergency responder cohorts are also included here: ambulance crews, law enforcement officers, firefighters who attend suicides, nurses in accident and emergency working with self-harm. The review only included papers in the English language. It included papers dealing with jurisdictions other than England and Wales due to maximise understanding. The review helped signify existing themes, identified the research gaps and provided the foundation for data collection, namely shaping the interview guide. The second part of the literature review provides introductory summaries, to define and introduce relevant concepts to the reader prior to the findings and analysis chapters herein.

2a.ii) The importance of prison staff in reducing and preventing self-harm and suicide

Prior to examining the core literature, this brief section outlines why prison staff and the occupational cultures they inhabit are so crucial in reducing and preventing prisoner suicide and self-harm. Good prisoner relationships with staff are a cornerstone in determining the prison social climate and its emotional and moral dimensions (Auty and Liebling, 2020) and can enable functional institutions (Liebling *et al.*, 2011). Good staff-prisoner relationships are key to reducing suicides (Liebling, 1998; Ludlow *et al*., 2015; Howard League, 2017) and aid

prevention of self-harm (Kalra *et al.*, 2016; Marzano *et al*., 2013; Short *et al*., 2009; Tait, 2008; Walker *et al.,* 2016). This includes healthcare staff, who may be emergency first responders administering resuscitation or those working longer-term with prisoners, e.g. psychologists or substance misuse nurses. Prison staff are essential in the 'identification of risk and the provision of support [for prisoners], despite often feeling unqualified, untrained, or unskilled for this kind of work', and can receive limited care or support (Marzano *et al.,* 2013: 2). Prison staff have high levels of exposure to traumatic incidents at work (Bell *et al*., 2019; Kinman *et al*., 2016; Liebling, 1998). These incidents and experiences have an impact on prison staff (Garbutt and Casey, 2013) and 'prison staff determine regime and quality of life for all in their care' (Short *et al.,* 2009). Put simply, staff-prisoner relationships are fundamental: how prison staff respond to their past experiences of prisoner suicide and self-harm, will affect their future attitudes and practices with prisoners who are suicidal and self-harming.

2a.iii) Prison staff and prison occupational culture

A prison's culture and values are 'inextricably linked', constituting a 'major component of the quality of prison life' (Liebling *et a*l., 2004: 464). Within these, prison occupational cultures also vary from institution to institution, impacting on prisoners' daily lives (Liebling, 2007). These cultures can be understood as 'processes', dynamic and evolving, they are 'continually lived out, enforced and reinforced' and influenced by a range of factors (Crawley and Crawley, 2008: 137, 142). These factors include but are not limited to: the type and age of the prison, local employment sectors and the ethos of the prison (Sparks *et al*., 1996). Staff attitudes can inform behaviours and as such, shape culture, but are 'mediated by forms of competence and professionalism', which are themselves connected to 'levels of experience and staffing ratios' (Crewe *et al*., 2011: 111). Cultures can also differ between occupational groups in the prisons, e.g. governors/managers or psychologists will have distinct occupational cultures (Bennett, 2016 and Warr, 2020 respectively). Work on prison officer culture highlighted four aspects: 'a) an expectation of solidarity between members; (b) suspicion; (c) feelings of social isolation; and (d) an emphasis on physical courage' (Crawley and Crawley, 2008: 137). Other scholars conclude officer occupational cultures evolve from values of 'security, loyalty, protection and mistrust', undergirded by a sense being there to 'care' for prisoners (Arnold, 2016: 271). Seemingly "traditional" prison officer cultures could contribute to improved safety, fairness

and operational delivery, when they were traditional-professional cultures – 'confident, boundaried, clear, vigilant and knowledgeable', instead of the cynical, unhelpful traditional-resistant cultures (Crewe *et al*., 2011: 111). Occupational cultures affect prisons' varied moral and relational climates, a key aspect of variation being how 'prisoners were treated by staff', making some prisons more 'survivable' than others (Liebling, 2011: 534), and therefore relevant to this thesis.

2b.i) Prison staff experiences of and perspectives on prisoner self-harm

The studies included in this section either contain staff experiences and responses to prisoner self-harm as the focus, or cite staff attitudes, behaviour and responses to self-harm as part of a wider study of drivers for self-harm. Most of the literature considers prison officers, though some contain a small cohort, e.g. three people, of healthcare staff in their sample (Garbutt and Casey, 2013; Kenning *et al.*, 2010; Marzano *et al.*, 2013; Ramluggun, 2013; Short *et al.*, 2009; Walker *et al.*, 2016; Walker *et al.*, 2017). The key themes identified by this section of the narrative review were:

i) Prison staff responses to self-harm influenced by prison environment
ii) Interdisciplinary conflict and role conflict
iii) Staff perceptions of prisoners' self-harm: "genuine" and "non-genuine"
iv) Impacts on staff behaviour due to perceptions of self-harm
v) Impacts on staff of exposure to self-harm
vi) Staff training and support.

2b.i.i) Prison staff responses to self-harm influenced by prison environment

Staff responses to self-harm are influenced by a variety of factors, including the work environment with its 'poor facilities, overcrowding and a lack of resources.' (Walker *et al.*, 2016: 182; also see Bell *et al*., 2019). The environment is understood here as: staffing levels, numbers of prisoners, nature of regime and culture amongst staff, not just architecture. Environment was important in how staff carried out their duties (Bennett and Dyson, 2014), with operational conditions inhibiting officers' confidence in carrying out their duty of care to prisoners (Liebling, 1998). One study found that a lack of staff and being 'over-stretched appeared central to officers' responses to repetitive self-harm, with some making direct links

between resourcing/staffing and their reactions to these behaviours' (Marzano *et al..,* 2013: 10). This suggests the prison environment is a contributory, dynamic factor in how staff respond to self-harm.

2b.i.ii) Interdisciplinary conflict and role conflict

Tensions could arise between officers and healthcare staff when responding to self-harm, regarding whose "responsibility" the self-harming prisoner was (Bennett and Dyson, 2014; Borrill *et al.*, 2005; Ramluggun, 2013). Custodial staff typically found motivations for self-harm harder to understand than nursing staff, were prone to categorising it as "mental health" and therefore a healthcare staff problem; nurses commonly viewed self-harm as a behavioural problem and therefore an issue for officers (Ramluggun, 2013). Organisational issues, such as poor multi-agency working and poor communications also caused tensions, impeding the quality of responses to prisoners (Pope, 2018; Ramluggun, 2013).

As set out in 2a.ii), good staff-prisoner relationships are essential in preventing self-harm, yet this repeatedly conflicted with security (Walker *et al.*, 2016). The tension for prison staff between care and custody is well documented (Crawley, 2004a; Liebling *et al.*, 2012; Tait, 2008), and was also experienced by staff working with prisoner self-harm (Liebling *et al.,* 2005; Short *et al*., 2009). Where staff feel unconfident or lacking in training to work with self-harm, they default to security rather than safeguarding as a means of prevention: this was found to be the case for healthcare staff too (Short *et al.,* 2009; Smith *et al.*, 2019). How prison staff use authority is noted 'a key determinant of prisoner experience', staff attitudes being mediated by their 'experience and competence, as well as attitudes' (Crewe *et al.,* 2011: 96). Occupational cultures marked by high numbers of inexperienced staff in Crewe and colleagues' paper in a private prison, meant officers less able to the 'model confident authority', which was associated with traditional-professional cultures, enabling higher ratings from prisoners on safety and fairness. How prisoners' experience this tension, or indeed balance between care and custody significantly impacts on their perceptions of the quality of their prison life (Crewe *et al.,* 2011; Liebling, 2007). Another role conflict experienced by staff was between being supposedly agentic actors, and feelings of powerlessness evoked by prisoner self-harm (Marzano, 2007; Marzano *et al.*, 2013), illustrating the profound difficulty of working with self-harm.

2b.i.iii) Staff perceptions of prisoners' self-harm: "genuine" and "non-genuine"

Prison staff could perceive prisoner self-harm as manipulative (Dixon-Gordon *et al.,* 2012; Walker *et al.,* 2017), as either well-behaved or disruptive (Ireland and Quinn 2007), bad behaviour (Borrill *et al.*, 2005), or genuine or non-genuine (Kenning *et al.*, 2010; Short *et al.*, 2009). Where "non-genuine" motives for self-harm were cited, prison officers attributed motivations such as manipulation and attention seeking (Kenning *et al.*, 2010; Smith *et al.*, 2019) with prisoners perceived as 'rational manipulators' (Short *et al.*, 2009: 417), using self-harm to change their environment or circumstances (Ramluggun, 2013). This individualises responsibility for the act of self-harm, situating power and agency with the person self-harming (see also, Coles and Ward, 1994). Additionally, these "non-genuine" cases could elicit resentment and negativity towards prisoners (Ireland and Quinn, 2007; Ramluggun, 2013; Short *et al*., 2009), enabling officers to minimise and deny impacts on themselves (Smith *et al.*, 2019). Self-harm construed as or that is "manipulative" may also be life-threatening and demonstrate suicidal intent (Dear *et al.*, 2000). It can lead to unintentional death (Suto and Arnaut, 2010). Labelling self-harm as manipulative can 'legitimise hostile responses to prisoners who injure themselves' and limit staff responses (Snow, 2002: 21).

Literature for this theme demonstrated an elevated expectation on prison healthcare staff to respond to *all* patients in a caring way (Marzano *et al.*, 2013). Healthcare staff also used the labels of "genuine" and "non-genuine" self-harm, though the evidence is mixed and limited. For example, in small single-site study samples in the female estate, healthcare staff were found to engage in such labelling less frequently than their officer colleagues (Short *et al.*, 2009). Healthcare staff cited motivations aligned with reasons given by the prisoners for self-harm: affect regulation and/or self-punishment (Kenning *et al.*, 2010). There was a paucity of information about the processes that led staff to these attitudes and beliefs about prisoner self-harm. This thesis speaks to this gap.

2b.i.iv) Impacts on staff behaviour due to perceptions of self-harm

Staff attitudes towards self-harm are part of a wider belief system regarding the purpose of prison, impacting how staff work with prisoners (Garland and McCarty, 2009). This matters because, as Marzano *et al.* (2012: 2) note, 'Negative staff reactions and attitudes may also

increase the likelihood of prisoners self-harming by exacerbating their distress and reinforcing feelings of isolation, low self-worth, and loss of control which may have led to their self-harming in the first place'. Staff perception of self-harm as either "genuine" or "non-genuine" and manipulative, affected staff responses to it (Ireland and Quinn, 2007; Kenning *et al.*, 2010; Smith *et al.*, 2019; Short *et al.*, 2009). Negative attitudes towards self-harm could arise from a lack of training and feeling poorly equipped (Borrill *et al.*, 2005; Ireland and Quinn, 2007; Kenning *et al.*, 2010; Ramluggun, 2013). Angry, cynical responses to self-harm are difficult for staff and result in poorer relationships with prisoners, damaging outcomes (Marzano *et al.*, 2013). When self-harm is repeated, these negative attitudes are more prevalent (Marzano *et al.,* 2013). Positive staff attitudes are potentially helpful in implementing care, but are rare in officer staff (Bennett and Dyson, 2014). Attitudes, thoughts and feelings are not immutable and offer a pathway to change in an environment that can seem intransigent (Bennett and Dyson, 2014). If negative attitudes can be changed, the response to those who self-harm can be improved (Patterson *et al..*, 2007). As in 2b.i.iii above, a better understanding of *why* staff hold particular attitudes would enable this, including the barriers and catalysts to change.

2b.i.v) Impacts on staff of exposure to self-harm

Staff respond in different ways to exposure to self-harm. Officers described flashbacks, nightmares and "taking it home" following involvement with prisoner self-harm (Marzano *et al.*, 2013). Staff "cope" in different ways with prisoner self-harm, in part depending on the frequency and severity of it (Walker *et al*., 2017). Minimising the impacts to cope was common amongst officers (Kenning *et al.*, 2010; Marzano *et al.*, 2013), with some mental health staff minimising incidents as 'irritating disturbance', even when i extreme (Smith *et al*., 2019: 12). This could be accompanied by a rejection of any impacts on their own mental health and an 'externalising to additional workloads and disruptions to other prisoners and/or the prison setting' (Smith *et al..,* 2019: 13). In two studies, healthcare staff were less likely to deny the impacts of exposure to self-harm on them than officer staff (Gamble *et al.*, 1994; Kenning *et al.*, 2010). Not all officers and healthcare staff working with self-harm reported adverse effects (Bell *et al.*, 2018; James and Todak, 2018; Kinman *et al.*, 2016). However, where these studies use self-reported quantitative measures and their findings must be viewed cognisant of minimising's prevalence as a coping strategy amongst staff.

Qualitative studies found emotional detachment is viewed as necessity to enable staff's continuing work in environments with a high prevalence of self-harm (Liebling *et al.,* 2005; Sweeney *et al.,* 2018; Walker *et al.*, 2017). Such 'hardening' and can be either a sign of a highly evolved coping mechanism or an example of 'emotional blunting' and a burnout indicator (Marzano, *et al.* 2013; Walker *et al.*, 2017). Staff felt they must present a 'façade of coping', even when struggle emotionally (Walker *et al.*, 2017). It is therefore unsurprising that in another study, staff were willing to cite others' (poor) coping strategies but not to discuss their own (Smith *et al.*, 2019). Hewson *et al.*'s (2022: 7) review found staff construed emotional distancing to be an 'effective defence mechanism to limit the emotional effects of self-harm', but noting it may lead to poorer risk management and identification and cynicism towards prisoners. The complexities of staff responding with emotional detachment revealed here, demonstrate the need for further qualitative studies that seek to understand the impacts of the work, as well as understanding staff's ways of coping. The only study here that deals exclusively with healthcare staff is Smith *et al.*, (2019), which is based on a different jurisdiction. Other studies here contain small numbers of healthcare staff as part of a wider staff cohort, e.g. three healthcare staff in a sample of 14 in Walker *et al.,* (2017). As such, the specificities and divergences of healthcare staff from the officer cohort may be somewhat obscured. This thesis addresses the lack of qualitative investigation into prison healthcare staff in England and Wales and how they used emotional detachment in their work with prisoner self-harm and explores the implications.

2b.i.vi) Staff training and support

Staff frequently cited the need for more training and support to sustain them in their work with prisoners who self-harmed (Hewson *et al.,* 2022; Walker *et al.*, 2017). Bennett and Dyson's (2014) literature review found a 'lack of knowledge… and lack of training in how to deal with such incidents were barriers to implementing prevention strategies'. A greater focus on equipping staff to deal with repeated self-harm was needed (Marzano and Adler 2007; Marzano *et al.*, 2013). Staff understanding of self-harm can increase with additional training (Dixon-Gordon *et al.*, 2012; Short *et al.,* 2009), having a positive influence on the attitude of those who have undertaken it (Dickinson *et al.*, 2009; Pannell *et al.*, 2003). Better training for staff could also lead to increased confidence in dealing with self-harm, including highlighting positive staff work, and therefore aid the reduction of self-harm (Borrill, 2005; Kenning *et al.*

2010; Smith *et al.*, 2019). The quality of such training matters. Not training on protocols, procedures and paperwork, but training that unlocks understanding as to prisoner self-harm (Ramluggun, 2013). In terms of support, staff did not feel supported in their work with prisoner self-harm (Marzano and Adler, 2007; Walker *et al.*, 2017). Supervision was found to be the strongest predictor of job satisfaction for prison healthcare staff (Garland and McCarty, 2009). Though staff could avoid formal support within prisons (Marzano, 2007; Sweeney *et al.,* 2018), partially due to avoid the appearance of poor coping (Hewson *et al.,* 2022; Ramluggun, 2013). This concern prevented some officers from sharing with peers, though nurses were happy to discuss their responses to self-harm with their peers (Ramluggun, 2013). Staff training and support that aids their understanding of self-harm and improves their interactions with prisoners who self-harm would be beneficial. Understanding how staff are supported and sustained in working with self-harming prisoners would provide a novel contribution to knowledge, which this thesis does.

2b.ii) Prisoner suicide scholarship that includes prison staff perspectives

This section of the narrative review incorporates literature illustrating the experiences and impacts of prisoner suicide on staff. Recent scholarship notes the gap here, 'few scholars have empirically examined the effect of responding to completed death by suicide on correctional staff' (Ricciardelli *et al.,* 2021: 5). None of the studies included here were exclusively with prison healthcare staff; unless explicitly stated, staff here are officer staff. Section ii) of this literature review includes five key themes, explored chronologically. The themes were:

i) Staff responses: immediate responses and processing
ii) The impacts of prisoner suicide on staff perceptions and behaviours
iii) Long-term and profound mental health and wellbeing effects
iv) Support for staff
v) Potential protective factors.

2b.ii.i) Staff responses: immediate responses and processing

Following a prisoner's suicide, staff may initially experience indifference, blame and anger (Borrill *et al.,* 2005; Slade *et al*., 2019). Guilt and sadness can be present (Barry, 2017; Borrill

et al., 2004), as can shock and upset (Liebling 1998; Sweeney *et al.,* 2018). The expectations of peers and institutions resulted in minimising emotional expression, 'the so-called feeling rules', which then impaired staff's ability to cope (Slade *et al*., 2019: 37). Officers often dealt with difficult feelings by employing denial, dark humour (Liebling 1998; Sweeney *et al.,* 2018), an increase in solidarity with colleagues and avoidance (Liebling, 1998). Coping strategies of faking emotions were detrimental to staff's resilience, due to the emotional dissonance created (Slade and Lopresti, 2013). Cultures of minimising and denying difficult feelings created by suicide can diminish suicide's significance and normalise its occurrence, leaving staff with reduced routes to seek support. None of the literature relevant to this theme explicitly drew on healthcare staff experiences, an important gap which this thesis addresses.

2b.ii.ii) The impacts of prisoner suicide on staff perceptions and behaviours

Exposure to suicide impacts staff *perceptions* of prisoners, which has implications for efforts to reduce suicides and self-harm. Staff stigmatisation of prisoners may be a '*significant yet underreported* driver of prison suicide' (Tomczak, 2018:21; emphasis in the original). Staff who view suicide as primarily a mental health problem and/or as a tool of manipulation (Dear *et al.*, 2000; Sweeney *et al.,* 2018; Towl and Crighton, 2017) locate the cause of suicide within that individual. Narratives of individuals determined to die by suicide, irrespective of external factors or staff intervention, abrogate staff responsibility (Liebling and Krarup, 1993; Ludlow *et al.,* 2015), and, this thesis suggests, state responsibility. That abrogation impacts the effectiveness of prevention. It indicates a need to better understand the contingent nature of suicide and the constraints on staff aiming to prevent it. This thesis speaks to this gap.

Staff workplace *behaviour* is affected by experiencing prison suicide (Liebling, 1998; Slade *et al.,* 2019; Sweeney *et al.,* 2018). Staff noted a crisis of confidence, avoidance of routine tasks, questioning their usefulness in suicide prevention and fearing being viewed as incompetent (Slade *et al.,* 2019). Following several suicides, officers could become risk averse in their daily practice, anticipating the worst-case scenario (Liebling, 1998; Read and Noonan, 2018). Staff can experience 'institutional apathy' (Tomczak, 2018: 17) or adopt the prisoners' 'institutionalised loss of hope' (Read and Noonan, 2018: 27). For example, Tomczak's (2018:17) participant commented, 'Prisons that have individually had a lot of self-inflicted deaths […] that has a kind of deadening effect […] "it's not my fault" becomes "there is nothing

I can do about it."' Most officers are not indifferent to prisoners when they start working (Morrison and Maycock, 2020), suggesting institutional apathy and institutional hopelessness may be part of the impacts on staff following prison suicide. Given its potential significance for reducing suicides in prison, this theme requires further exploration, which this thesis does.

2b.ii.iii) Long-term and profound mental health and wellbeing effects

Exposure to prison suicide can create ongoing, serious mental health impacts (Barry, 2017; Borrill and Hall, 2006; Crawley, 2004a; James and Todak, 2018: Liebling, 1998; Slade *et al.*, 2019; Sweeney *et al.,* 2018; Tomczak, 2018). Several studies find a correlation between staff exposure to prison suicide and Post-Traumatic Stress Disorder (Cassidy and Bruce, 2019; James and Todak, 2018; Wright *et al.,* 2006). As with self-harm findings in section 2b.i) above, a longer-term impact of working with suicide is becoming emotionally 'hardened' (Read and Noonan, 2018: 27). Staff also reported feeling hopeless (Read and Noonan, 2018), experiencing flashbacks (Borrill and Hall, 2006; James and Todak, 2018; Marzano *et al.,* 2013; Sweeney *et al.,* 2018) and being too traumatised by previous exposure to respond effectively to a new death in custody (Howard League, 2016; Tomczak, 2018). Some staff experienced 'ongoing intrusive memories and emotional saliency over many months or years' (Slade *et al.,* 2019: 56), being 'enduringly connected' to the suicide (Barry, 2017: 53; see also Crawley, 2004b; Garrihy, 2021; Wright *et al*., 2006). Many officers experienced long-term effects, with indicators for poorer outcomes (Arnold, 2012; Cassidy and Bruce, 2019; Slade *et al*., 2019). The studies cited are mainly drawn from quantitative work and a literature review (except Arnold, 2012). For many staff there are long-term and profound effects from suicides, meaning significant impacts for them, their families and communities and their work. Some staff also manage to use these deeply difficult experiences positively, e.g. improving their practice (Ludlow *et al.*, 2015; Walker and Towl, 2017). More qualitative work is needed to complement the quantitative studies, to illuminate not just *who* may experience poorer outcomes but *why* previous or intense exposures indicated poorer outcomes and any possibilities for mitigation. Only the Read and Noonan (2018) study included prison healthcare staff, illustrating the need for further research into their experiences, and understanding the implications for prisoners in their care.

2b.ii.iv) Support for staff

As with prisoner self-harm, the *lack* of effective support for staff following suicide, was identified and was widespread in the literature (Cassidy and Bruce, 2019; Ludlow *et al.,* 2015; Slade *et al.*, 2019; Sweeney *et al.,* 2018; Tomczak, 2018; Wright *et al.,* 2006). Prison staff should be supported after suicide because they matter as people, employers have a duty of care towards them and to minimise future repercussions on prisoners. The effective support of prison staff may underpin effective post-vention – that is what happens after an incident – and the prevention of further prisoner and staff deaths. Staff preferred support from colleagues, rather than formal mechanisms such as Staff Care Teams (Ludlow *et al*., 2015), perhaps because stigma about accessing support persists (Garrihy, 2021; Sweeney *et al.,* 2018; Tomczak, 2018; Walker *et al.,* 2017). Nevertheless, effective institutional responses are required for the institutional problem of poorly supported staff. Literature suggests that support services should be offered on an 'opt-out' basis to increase participation and reduce stigma, along with facilitated team-based support and reflection sessions (Ludlow *et al.,* 2015; Slade *et al.*, 2019). Two studies propose that those with greatest proximity or cumulative exposure to suicide should be prioritised for support (Cassidy and Bruce, 2019; Slade *et al.*, 2019). Prisons that encouraged reflection and subsequently improved their practices following a suicide were also prisons that had offered sufficient support to staff, including at inquest (Ludlow *et al.,* 2015). Recognising the role of staff in preventing a suicide may also increase prevention and reduce negative introspection in staff (Sweeney *et al.,* 2018). Supporting staff and equipping them can help to halt the 'vicious circle' (Tomczak, 2018: 17) that can occur when 'unsupported staff… leave prisoners feeling unsupported' (Liebling, 1998: 80). This thesis explores what support prison healthcare staff have found helpful in sustaining them in their work with suicidal prisoners.

2b.ii.v) Potential protective factors

Staff who were well supported, optimistic, self-efficacious, and confident in problem-solving, experienced these as potential protective factors against becoming traumatised by the work (Cassidy and Bruce, 2019). Staff who were able to respond to suicides with emotional congruence were more resilient (Slade and Lopresti, 2013). Both studies were large quantitative studies, without healthcare staff in their sample and as such do not provide data as to why these things were protective for staff. They also locate the protective factors within the individual member of staff and do not consider collective or structural protective factors.

There is a research lacuna on a wide range of potential protective factors that might sustain staff working with prisoner suicide: this thesis speaks to this gap.

2b.iii and 2b.iv: staff responses in parallel settings experiencing suicide and self-harm

Literature on staff responses to self-harm and suicide in parallel settings enriches the scant information on prison healthcare staff and is illuminating in its divergence and congruence with the, predominantly officer, prison literature. Parallel settings and work includes: secure psychiatric settings, acute mental health settings, ambulance crews and other emergency responders e.g. firefighters, who attend suicides and nurses in accident and emergency.

2b.iii) Parallel settings scholarship about staff encounters with self-harm at work

This section summarises literature about the impacts of self-harm at work on professionals in settings parallel to prisons. This review includes six papers, three of which are literature reviews (Karman *et al.,* 2015; Pompili *et al.,* 2005; Saunders *et al.,* 2012), two of which are small-scale qualitative studies with 16 and six participants respectively (O'Hara *et al.,* 2021; Wilstrand *et al.,* 2007) and one study that devised a quantitative measuring tool – the Self-Harm Antipathy Scale (Patterson *et al.,* 2007). There is a body of work on nurses in community healthcare settings responding to self-harm, for expedience, there are two literature reviews encompassing this literature. Papers not directly relevant to the research questions were excluded. This foray into parallel literature reinforced the findings of sections 2b.i and 2b.ii: much of the literature does not explore staff experiences of self-harm nor any impacts on staff resulting from exposure to self-harm. The two qualitative studies included here are unusual in providing insights (O'Hara *et al.,* 2021; Wilstrand *et al.,* 2007) and the Pompili *et al.* (2005) literature review offers a little commentary. This review found three themes:

i) Attitudes towards self-harm

ii) Emotional and psychological impacts on staff

iii) Training and support.

2b.iii.i) Attitudes towards self-harm

The attitudes of staff towards patients matters because of the impacts this can have on patients' actions (Pompili *et al.,* 2005). Negative attitudes towards self-harming patients were

prevalent across these studies (Karman *et al.,* 2015; Pompili *et al.,* 2005). Saunders *et al.* (2012) review, which included 74 papers, noted the extent of negative attitudes in medical and nursing staff across settings, across countries, and in both older and more recent studies: seven of the studies found staff had hostile attitudes to those who self-harm. Negative attitudes were more widespread amongst staff in generic healthcare settings, than in specialised mental health staff (Karman *et al.,* 2015; Pompili *et al.,* 2005; Saunders *et al.,* 2012). Generic healthcare staff had significantly higher antipathy levels than those in mental health settings (Patterson *et al.,* 2007). Attitudes towards patients who *repeatedly* self-harmed were negative (Saunders *et al.,* 2012). Most generic settings staff viewed self-harm patients more negatively than any others, except substance misuse patients, risking further patient stigmatisation (Saunders *et al.,* 2012). Those with greater work experience often had more positive attitudes (McCann *et al.,* 2006; Pompili *et al.,* 2005; Saunders *et al.,* 2012): this is a significant finding from the parallel literature given the high rates of staff attrition in prison healthcare. As with the prison-based literature, studies reviewed did not explore the reasons for negative attitudes towards those who self-harm, a gap this thesis speaks to.

Empathetic approaches, or "positive" attitudes in healthcare staff working with people who self-harmed were also present, sometimes co-existing with negative ones within a staff member or setting (Karman *et al.,* 2015). Staff could be understanding and empathetic (Karman *et al.,* 2015; O'Hara *et al,* 2021; Patterson *et al.,* 2007) or aiming to understand, being more sympathetic to those with psychiatric diagnoses who self-harmed than those without formal diagnosis (Saunders *et al.,* 2012). Staff were able to feel hopeful about their work (Karman *et al.,* 2015; O'Hara *et al,* 2021), finding it rewarding and taking pride in it (Karman *et al.,* 2015; O'Hara *et al,* 2021); they aimed to be non-judgemental (Karman *et al.,* 2015). This diverged from prison findings. There was a portion of staff demonstrating empathy towards patients and who take job satisfaction from the complex and difficult work they do. Much of the literature reviewed is quantitative studies that utilise self-reported questionnaires for data generation. Karman *et al.* (2015) caution that their findings may in fact underplay negativity, as most participants are optimistic in self-reporting. This thesis uses a qualitative semi-structured interview methodology to enable participants to explore their experiences of prison suicide and self-harm in their own words at their own tempo. This data may then illuminate how these practitioner attitudes are linked to the experiences of the staff.

2b.iii.ii) Emotional and psychological impacts on staff

Staff experience a range of emotional and psychological responses when encountering self-harm in their workplace (Karman *et al.,* 2015; Saunders *et al.,* 2012). These include: hopelessness (Pompili *et al.,* 2005), uncertainty and anxiety/fear (Karman *et al.,* 2015; Pompili *et al.,* 2005; Wilstrand *et al.,* 2007), guilt, failure and feeling discouraged (O'Hara *et al.,* 2021). Almost all studies reported that staff experienced feelings of powerlessness (Karman *et al.,* 2015; O'Hara *et al.,* 2021; Patterson *et al.,* 2007; Saunders *et al.,* 2012; Wilstrand *et al.,* 2007) and frustration (Karman *et al.,* 2015; O'Hara *et al.,* 2021; Pompili *et al.,* 2005; Saunders *et al.,* 2012; Wilstrand *et al.,* 2007). Unlike the prison literature, studies contained more difficult responses to working with self-harm. Staff could be deeply affected by a single occurrence of self-harm (O'Hara *et al.* 2021), staff can be traumatised, meaning clinicians can have 'difficulty regulating emotions, become more sensitive to violence, become numb, feel less self-worth or have difficulties in keeping a connection with others' (Pompili *et al.,* 2005: 170). Another study characterised this as staff being 'burdened with feelings', which could compromise their ability to care for patients (Wilstrand *et al.,* 2007: 74). Staff were overwhelmed by repeated self-harm and experienced hyper vigilance, knowing that self-harm can prove fatal (Wilstrand *et al.,* 2007). Most staff experienced 'emotionally charged memories' about self-harm they had seen or had to deal with, reporting heightened sensory recollections even some years later (O'Hara *et al.,* 2021: 5). Much like the prison literature, staff used strategies to distance themselves from difficult feelings, so they could continue to work (O'Hara *et al.,* 2021; Wilstrand *et al.,* 2007). Strategies of inhibiting feelings, becoming desensitised and rationalising reactions were employed to avoid displaying emotion; the demonstration of feelings was associated with unprofessionalism (O'Hara *et al.,* 2021). Rarely did staff become avoidant of working with those who self-harm altogether (Karman *et al.,* 2015). Staff questioned their competence and perceived their professional abilities as diminished following work with people who self-harm (Karman *et al.,* 2015; O'Hara *et al.,* 2021; Patterson *et al.,* 2007). This literature is illuminating in its divergence from prison literature, which is mainly concerned with officers. It highlights the need for research with prison *healthcare* staff to understand their responses and how they affect prisoners in their care.

2b.iii.iii) Training and support

As in prison settings, training and support are crucial for healthcare staff working with self-harm to improve care and outcomes. Training on self-harm improved practice across medical settings (Karman *et al.,* 2015; Patterson *et al.,* 2007; Pompili *et al.,* 2005; Saunders *et al.,* 2012) and increased practitioner knowledge (Saunders *et al.,* 2012). Practitioners who had studied approaches for working with self-harm had a significantly lower antipathy score than those who had not undergone training (Patterson *et al.,* 2007). Training can reduce clinicians' fear and helps remove the stigmatising attitudes (Pompili *et al.,* 2005). Interventions should contain reflective and interactive elements to increase knowledge and understanding of self-harm (Karman *et al.,* 2015). Training can shift practitioner attitudes, enabling more effective suicide prevention by equipping staff to engage empathetically with self-harming patients (Pompili *et al.,* 2005). These studies suggest that the poor attitudes that engender poor practice are not immutable. Perhaps the roots of some unempathetic attitudes are fear, a lack of knowledge and confidence: these could be addressed. Administrative tasks could sometimes hinder support being offered (O'Hara *et al.,* 2021) and where staff were excluded from debriefs, they then felt unheard by management (Wilstrand *et al.,* 2007). There is a notable divergence here from the prison literature. There were few mentions of staff reticence to access formal support and in-work support structures were championed, alongside the support provided by peers and at home. Staff training in self-harm is clearly a key part in the prevention of suicide attempts and self-harm, but how possible it is for *prison* healthcare staff to access such training is unclear.

2b.iv) Parallel settings scholarship about staff encounters with suicide at work

This section reviews nine papers that consider the impacts of suicide attempts and deaths on practitioners in professional contexts. The papers range from a literature review (Séguin *et al.,* 2014), to a nine person qualitative interview sample within one work setting (Nelson *et al*., 2020), to a quantitative study with over 800 respondents (Cerel *et al.,* 2018). The literature is reviewed thematically given the diversity of the studies involved in this review and the difficulty of direct comparison. Most of the participants were working in healthcare settings; one paper concerned with fire fighters (Kimbrel *et al.,* 2016) and one paper concerned with law enforcement officers (Cerel *et al.,* 2018). This review groups findings into four main themes:

i) Emotional and psychological impacts

ii) Impacts on professional practice

iii) Cumulative impacts

iv) Staff support.

2b.iv.i) Emotional and psychological impacts

All nine papers found there were emotional and psychological impacts on practitioners encountering workplace attempted and completed suicide. Emotions experienced included: 'shock, sadness/sorrow, failure, guilt, feeling of incompetency, disbelief, helplessness, discouragement, self-condemnation, anger/betrayal, feeling of depression, shame, fear of blame' (Séguin *et al.,* 2014: 343). In most cases, the emotional impacts of encountering suicide were significant or major (Cerel *et al.,* 2018; Chemtob *et al.,* 1988; Gibbons *et al.,* 2019; Nelson *et al.,* 2020), with these experiences regarded as 'uniformly stressful events' (Chemtob *et al.,* 1989: 297). Emotional impacts were persistent and long-lasting (Alexander *et al.,* 2000; Awenat *et al.,* 2017; Cerel *et al.,* 2018; Chemtob *et al.,* 1989; Nelson *et al.,* 2020). Although, Wurst *et al.* (2011) state cumulative exposure leads to increased practitioner distress, they also – in contrast to other studies – found that all emotional reactions to patient suicide, except relief, decreased over time. Most studies agreed emotional impacts may continue over months and years. Time is important in this thesis, the effects of suicide on staff are long-lasting. This thesis is interested in temporality and how suicides may affect prison healthcare staff over time.

Other psychological impacts cited included: poor sleep, low mood, irritability (Alexander *et al.,* 2000); severe distress (Awenat *et al.,* 2017; Wurst *et al.,* 2011) - although this may be supressed (Nelson *et al.,* 2020); and nightmares and or 'a scene that stayed with them' (Cerel *et al.,* 2018: 1285). Having persistent flashbacks is statistically associated with increased symptoms of 'perceived burdensomeness, depression, anxiety, PTSD, and suicidal ideation' (Cerel *et al.,* 2018: 1287). The findings of Séguin *et al.*'s (2014) literature review of 115 papers disgaree. The range of emotions noted are deemed as immediate responses *only,* that seldom 'reach a clinical level' (Séguin *et al.*, 2014: 357). The authors cite the lack of measurement of 'the duration, the intensity, and the extent of its effect' of the emotions noted, stating

therefore, they cannot draw firm conclusions (Séguin *et al.*, 2014: 343). Most suicides were distressing in the immediate term for a professionals; for a portion of practitioners, there are salient, persistent, long-term emotional impacts. This thesis seeks to understand how healthcare staff in prisons are affected over time by working with prisoners who die by suicide, whilst they continue to work with prisoners who are suicidal and self-harming.

2d.iv.ii) Impacts on professional practice

All papers in settings with ongoing healthcare professional to patient relationships with suicidal people reported this theme. The studies concerning law enforcement officers (Cerel *et al.,* 2018), firefighters (Kimbrell *et al.,* 2016) and ambulance staff (Nelson *et al.,* 2020), where the relationship is not one that typically includes ongoing workplace relationships with suicidal people, did not have findings relevant to this theme. Exposure to suicide at work impacts professional behaviours and practices (Alexander *et al.,* 2000; Awenat *et al.,* 2017; Chemtob *et al.,* 1989; Gibbons *et al.,* 2019; Séguin *et al.*, 2014; Wurst *et al.,* 2011). It can change the way healthcare professionals undertake clinical assessments and determine the treatment of future patients (Séguin *et al.*, 2014). Changes reported included: hyper-vigilance with patients (Alexander *et al.,* 2000; Séguin *et al.*, 2014); greater caution and lacking clinical confidence (Alexander *et al.,* 2000; Gibbons *et al.,* 2019; Wurst *et al.,* 2011); and becoming risk averse, seeking a more structured approach to suicidal patients (Alexander *et al.,* 2000; Awenat *et al.,* 2017). In some cases, staff would refer suicidal patients to another colleague or avoid suicidal patients (Awenat *et al.,* 2017; Séguin *et al.*, 2014). Being involved with a suicide less frequently led to staff attrition, be that considering a career change (Gibbons *et al.,* 2019) or taking early retirement (Alexander *et al.,* 2000). The reported impacts on professional practice are serious and wide-ranging. There was no reported positive improvements to practitioner competency following suicides; though half used a quantitative methodology which potentially did not include such questions. It is notable that this theme relevant only to those settings with a relationship between the person who died and the professional. This requires further exploration in this prison-based thesis, where prisoner-staff relationships can span many years.

2b.iv.iii) Cumulative impacts

Not all papers directly considered the impacts of cumulative exposure to suicide. It is included here as salient to prisons with high rates of suicide and cluster suicides. Where stated, fire fighters encountered an average of 13 people who died by suicide (Kimbrel *et al.,* 2016) and law enforcement officers, an average of just over 30 (Cerel *et al.,* 2018). The first responder professions represented by these studies usually do not have an existing relationship with the deceased, unlike prison staff, but still provide some insights into the impacts of repeated exposure to suicide at work. Cumulative exposure to suicide was found to lead to higher levels of distress in psychiatric clinic staff (Wurst *et al.,* 2011) and was positively correlated with firefighters' own suicidal behaviour (Kimbrel *et al.,* 2016). There was a significant statistical association between high levels of exposure at work (over 10 deaths by suicide) and health consequences including PTSD, persistent and intrusive thoughts (Cerel *et al.*, 2018). Although not in healthcare settings, where measured, cumulative exposure to suicides at work led to greater distress and a higher likelihood of suicidal behaviour. There is a gap in both wider healthcare and prison literature on the cumulative aspects of impacts on staff, which this thesis addresses.

2b.iv.iv) Staff support

As with prison suicide, staff support was a core theme. Following exposure to suicide, professionals encountered highly variable levels of support at work (Séguin *et al.*, 2014). Colleagues, family and friends were the most utilised sources of support (Alexander *et al.,* 2000; Séguin *et al.*, 2014; Wurst *et al.,* 2011). In contrast to this theme in self-harm section above, there was a lack of training about dealing with workplace suicide, even in professions with habitually high levels of exposure to suicide (Awenat *et al.*, 2017; Cerel *et al.*, 2018; Nelson *et al.,* 2020). A lack of training could indicate a lack organisational support (Awenat *et al.,* 2017) and a reluctance to access formal support services (Nelson *et al.,* 2020). Gaps in training and support can lead to detrimental outcomes for patients and staff (Awenat *et al.,* 2017; Nelson *et al.,* 2020). Training and support was inconsistent across workplaces, with some failing to acknowledge the potential impacts of (cumulative) suicide exposure. Where implemented, case reviews and clinical audits provided opportunities for practitioners to learn from previous suicides (Alexander *et al.,* 2000; Séguin *et al.*, 2014). Suggestions for improving staff support included: a senior suicide lead clinician, support offered during any formal investigation or inquest processes, opportunities for reflection and information on

communicating with the family and friends of the deceased (Gibbons *et al.,* 2019). These provide some indicators for effective post-vention support for staff and highlights the lack of such suggestions for post-vention in the prison literature.

2c) Key concepts

2c.i) Occupational prison officer stress

Prison work is stressful work (Crawley, 2004a; Kinman *et al.,* 2016; Liebling *et al.,* 2012). Prison staff witness significantly more violence, self-harm and suicide than people in the general population (Bennett, Crewe and Wahidin, 2008). Prison officers report high levels of 'stress, depression, poor physical health and a sense of isolation', with the vast majority stating the role was unreasonably stressful (Liebling *et al.,* 2012: 65). Prison work is 'extremely stressful' because of the combination of the 'threat of victimization and exposure to violence and human suffering' combined with 'the demands, lack of control, and isolating nature of their work environment' (Ellison and Caudill, 2020). Prison work stress can create anxiety, tension and frustration (Lambert *et al*., 2016) and other physical and emotional impacts on staff, increasing sick leave and staff turnover (Dowden and Tellier, 2004). It can evoke feelings of 'anger, frustration, fear, guilt, sadness, tension, stress, upset, anxiety, tiredness, empathy, pity, relief and uncertainty' (Arnold, 2012: 409). Prison staff are affected by their high levels of exposure to these events, impacting their perceptions, behaviours and practice (Marzano *et al.,* 2013; Smith *et al.,* 2019; Tomczak, 2018; Walker *et al.,* 2017). Across geographies and type of prison, prison work is stressful and working with human suffering – including suicide and self-harm – is contributory to staff stress.

Prison officers stated the job was stressful, but wanted it acknowledged that this did not necessarily mean that *they* were stressed (Crawley, 2004a). Admitting to feelings of stress can lead to Goffman's spoiled identity (Goffman, 1986), which can then stigmatise the officer as unable to cope (Crawley, 2004b). A better understanding of staff experiences would help to understand and improve prisons (Liebling, 1992; 2011). The stress of staff matters in itself and, because it effects work with prisoners, as staff can prevent or exacerbate prisoner distress (Tait, 2008). As Liebling *et al.* (2005: 185) note, 'distressed prison staff are less able to empathise with prisoners and provide at-risk prisoners with support'. This then influences

prison safety (Auty and Liebling, 2020). There are consequences of workplace stress for prison staff and consequences for the prisoners in their care, including those who are suicidal and self-harming. Existing quantitative research does not 'effectively or adequately capture the more nuanced personal experiences of staff working within a prison environment' (Dennard *et al.,* 2021: 133). This thesis addresses this gap by providing qualitative insights about prison healthcare staff stress as related to prisoner suicide and self-harm and its consequences for practice.

2c.ii) Trauma in prison staff (disenfranchised trauma)

Prison work is not only stressful, it can be traumatic (Bell *et al*., 2018; Kinman *et al*., 2016; Liebling, 1998). Prison incidents can constitute a primary trauma or contribute to vicarious or secondary trauma (McKendy *et al.,* 2021; Power and Usher, 2014). Vicarious or secondary trauma is defined as 'resulting from empathetic engagement with clients' trauma material', that can be cumulative and permanent (Pearlman and Saakvitne, 2013: 151). Prisoner suicide can create primary trauma in staff (Barry, 2017; Ludlow *et al.,* 2015; McKendy *et al.,* 2021); as can even a single incident of self-harm (James and Todak, 2018; O'Hara *et al.,* 2021). Staff can experience clinical levels of trauma and exhibit PTSD symptoms following workplace experiences (James and Todak, 2018; Spinaris *et al.,* 2012); with PTSD occurrence higher amongst correctional officers than the general population and other public safety professions (Regehr *et al.,* 2019). In two quantitative self-report questionnaires, one found 32% of officers who had dealt with suicide in the previous year exhibited PTSD (Cassidy and Bruce, 2019); the other reported a similar 36.7% rate of PTSD for officers (Wright *et al.*, 2006). These traumatising experiences can have further consequences, McKendy and colleagues (2021: 11) highlight the 'hypervigilance, desensitization, a disillusioned sense of others, and an attitude of distrust and cynicism' of affected correctional workers. Prison workers are likely to be exposed to potentially traumatic events and accounts of traumatic events, which can contribute to experiencing trauma and its effects.

Group debriefing sessions following traumatic prison workplace events can reduce traumatic stress, anxiety and depression in staff (Ruck, Bowes and Tehrani, 2013). However, potentially traumatic experiences can go unacknowledged, leading to occurrences of *disenfranchised* trauma. Disenfranchised trauma is trauma arising from cumulative experiences and/or trauma

that cannot be openly acknowledged (Thompson and Doka, 2017). Therefore, it is unlikely to be a finding from a self-report quantitative questionnaire. Extant qualitative work is focused on officers, noting the need for 'future researchers to further explore the experience of other correctional staff (e.g. health care, governance)' (McKendy et al., 2021: 15). This thesis helps understand how a non-officer group – prison healthcare workers – experience working with prisoner suicide and self-harm and the effects on them, including possible trauma.

2c.iii) Moral injury

There is no agreed definition of moral injury, a term originating in medical sociology (Griffin *et al.,* 2019; Litz and Kerig, 2019). The most frequently utilised definition states it is 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations' (Litz *et al*., 2009: 697). Building on this, Farnsworth *et al.* (2017: 392) suggest that this has to happen 'in a high-stakes environment' to be potentially morally injurious. Moral injury does not have to include a threat to life, but events that threaten beliefs and/or trust (Williamson *et al.,* 2021). Two categories of potentially morally injurious events are proposed: those that involve 'people doing or failing to do things', deliberately or unwittingly, and those where people are 'exposed directly or indirectly to others' transgressions' (Litz and Kerig, 2019: 342). A short paper about prison clinicians in the Covid-19 pandemic suggests moral injury as 'complex psychological distress' when encountering events that people 'feel outweigh their skills, training and experience' (Kothari *et al.,* 2020: 165). The consequences of moral injury are significant, causing feelings of 'shame and guilt, and alterations in cognitions and beliefs… as well as maladaptive coping responses', being associated with PTSD, depression and suicidality (Williamson *et al.,* 2021: 453). It is an additional risk factor for the development of mental ill-health (Greenberg and Tracy, 2020) and was a significant predictor of higher overall PTSD symptoms in law enforcement staff (Papazoglou *et al.,* 2020). Based on an extensive review of the literature, scholars suggest moral injury is a biopsychosociospiritual phenomena, therefore strategies to address its outcomes need to work collectively and holistically (Griffin *et al.,* 2019). Most of the literature supports a definition of moral injury as transgressing a core belief, standard or truth, e.g. the morally injurious event, which then affects the person exposed to this transgression. This is the remit of the term as conceptualised here.

The roots of the concept of moral injury are in military and combat settings, existing studies reflect this. In the last decade there has been a growth of interest in the concept (Griffin *et al.,* 2019) and following the Covid-19 pandemic, it has been utilised more in healthcare staff studies (Williamson *et al.,* 2021). There is limited prison staff scholarship that uses the term. Dennard *et al.* (2021) suggest that officer staff may experience it when having to keep prisoners on longer lockdown due to staff absences. Ricciardelli *et al.* (2024) argue for an understanding of a continuum of moral harms, with moral injury at one extreme, exposure to which is deleterious for the mental health of correctional workers. Whilst not addressing the topic of moral injury, Liebling and colleagues have produced a body of work concerned with the moral performance of prisons, noting 'There is a moral intensity to prison life, which is linked to the fact that they are places full of power and deprivation' (Liebling, 2020: 80). Prisons vary, ranging from the morally tolerable to the morally deprived, that is those where people matter less, and which can create 'distress, anger and risk' (Auty and Liebling, 2024: 743). As such, those prisons may provide more fertile ground for morally injurious behaviours. In terms of moral injury itself, reviews of existing literature highlight its potential saliency to settings other than war zones and therefore the potential for future research (Griffin *et al.,* 2019; Litz and Kerig, 2021). As well as noting the dearth of qualitative work exploring 'the lived experience of individuals exposed to moral harms' and exposed to morally injurious events (Litz and Kerig, 2021: 343). This thesis addresses these gaps, particularly as it considers the cumulative impacts on working over time with prisoner suicides and self-harm. It builds on extant theory through a qualitative methodology, in this novel study of prison healthcare staff.

2c.iv) Normalisation

Foucauldian normalisation describes the process of norms becoming established, reproduced and embedded in a way that invisibilises the processes of normalisation (Foucault, 1977). Therefore, the process can go unnoticed and be difficult to reverse (Krzyżanowski, 2020), establishing the norm as 'natural, necessary and normal' (Taylor: 2009: 46). Normalisation can create limitations of 'thought and existence', consequently restricting the capacity to conceptualise alternatives and undertake alterative actions (Taylor, 2014: 6). Garland's foundational sociology of crime notes high rates of crime have become normalised, calling them a 'taken for granted element of late modernity', demonstrating how normalisation can lead to a lack of curiosity and exploration (Garland, 1996: 446). Aiming to reduce feelings of

stress and to do their job, prison staff 'minimised, normalised and controlled' their emotions 'to a significant extent' as they encountered events in prison that provoked strong responses (Arnold, 2017: 292). Healthcare practitioners in other settings noted becoming 'accustomed' to self-harm (O'Hara *et al.,* 2021: 6). A review of literature found prison staff frequently encountered self-harm, in some cases on every shift (Hewson *et al.,* 2022). Staff deemed prisoner self-harm as frequent, common, 'part of the job', which enabled staff to cope, but stopped short of naming self-harm as normalised (Walker *et al.,* 2017: 816). Fitzpatrick and colleagues (2023: 354) note 'there is also a serious need to guard against the normalisation of self-harm'. Studies around prison staff attitudes to self-harm chronicled staff's view of self-harm as manipulative and/or "genuine" or "non-genuine" (Kenning *et al.*, 2010; Pannell et al., 2003; Short et al., 2009). These attitudes are potentially an outcome of normalisation. Without better understanding how these attitudes arise in prison staff working with prisoner self-harm they remain difficult to address. Nascent research suggests healthcare staff have greater understanding of self-harm and so are less likely to hold these attitudes (Short *et al.*, 2009). Therefore, further research is needed to understand if healthcare staff conceptions of prisoner self-harm normalise self-harm and how any such conceptualisations effect their attitudes and practices with future prisoners who self-harm. This thesis provides these insights.

2c.v) Desensitisation of prison staff

Traumatic incidents in the prison workplace and their aftereffects can create desensitisation in prison staff (McKendy *et al.,* 2021). Officer staff describe themselves as 'hardened, cynical and detached', citing 'anger and frustration' as the most common emotions they experienced at work (Arnold, 2012: 410). Becoming desensitised when working with people who self-harm is reported across settings, e.g. staff in forensic settings became habituated and desensitised to self-harm as a protective strategy (O'Hara *et al.,* 2021). Prison staff could be desensitised following multiple exposures to incidents of self-harm (Liebling *et al.,* 2005; Marzano, 2007; Marzano *et al.,* 2013; Walker *et al.,* 2017). Being desensitised to prisoner self-harm did not mean staff being void of emotions; being desensitised may lead to cynicism, intolerance or anger with prisoners who self-harm (Marzano *et al.,* 2013). Being desensitised could enable staff to have an emotional distance from prisoners (DeHart *et al.,* 2009). Prison officers and prison healthcare staff in Walker *et al.*'s (2017) study indicated that their desensitised

responses to prisoner self-harm may have future deleterious psychological outcomes for them; but was deemed 'inevitable' because of the 'frequency of exposure… the range of severities and methods witnessed' (Walker *et al.,* 2017: 816). Prison staff used phrases like 'build up a tolerance' (Marzano *et al.,* 2013: 8): extant studies suggest desensitisation may be cumulative, without exploring that. Prison staff desensitisation, for coping, protective or other reasons, will have impacts for the staff themselves and those within their care. This requires further exploration to grasp the implications of desensitisation, as it pertains to prisoner suicide and self-harm.

2c.vi) Malignant alienation

Malignant alienation was originally used to describe a process of deterioration in relationship between staff and psychiatric in-patients (Morgan, 1979). Where staff found patients to be 'difficult, provocative and manipulative' it could result in hostility towards the patient (Whittle, 1997: 5); when this view persists, it alienates the practitioner from the patient (Watts and Morgan, 1994). It is malignant 'in that it gained momentum and was associated with a fatal outcome', that being suicide (Watts and Morgan, 1994: 11). The term is now used more broadly to indicate poorer patient outcomes, given that 'patients also experience alienation that has seriously detrimental associations (i.e. is malignant) but is not linked with suicide' (Whittle, 1997: 5). This study uses the wider conceptualisation of malignant alienation, e.g. resulting in detrimental patient(prisoner) outcomes. There is a small healthcare literature that cites malignant alienation, usually as a possibility or risk but not as a data-based finding, e.g. Patterson *et al.* (2007) found forensic nurses working with repeated self-harm experienced antipathy and were at risk of malignant alienation. Two papers cite malignant alienation as a finding: one used a case study methodology to suggest mental health nurses can find suicidal patients challenging, causing negative attitudes and actions from nurse to patient, resulting in malignant alienation (Duffy, 2003). Sullivan's (2013) informal survey in a women's secure forensic unit 'speculated that constant one-to-one observations might be a manifestation of malignant alienation', noting the negative cycle created between patient and healthcare worker. These findings are tentatively framed by the authors, in Duffy's (2003) case, they are based on one staff member and in Sullivan's (2013) case, the methodology is unclear. Notably, Whittle (1997) proposes that forensic psychiatric patients may be particularly vulnerable to malignant alienation due to the nature of the patients' offences, fear for personal safety, and

negative attitudes of staff to difficult patients. The concept has appeared in presentations regarding prison healthcare at conferences, e.g. Fiddler and Joliffe (2016), Walsh (2022), but there are no prison-based studies exploring malignant alienation or reporting it as an empirical finding. This thesis addresses this gap.

2c.vii) Staff experiences of coroners' courts

Coroners' inquests are deemed to be inquisitorial, tasked with understanding the circumstances of an individual's death, how, when and why they died (Tomczak, 2018). There is limited scholarship on coroners' courts: what exists is primarily concerned with their processes, critiques of these and the experiences of family members attending them. Staff's perspectives, people who are 'at the sharp end of events, policies, procedures, and often – of public and academic criticism', have still been seldom sought (Liebling, 1992: 69). The scant literature surrounding staff experiences of coroners' courts suggested attendance for professionals at inquest can create 'considerable anxiety' (Liebling, 1998: 72). They are deeply stressful (Borrill *et al.,* 2004), seen as adversarial (Baker, 2016; Snow and McHugh, 2002) and blame-seeking (Banwell-Moore *et al.,* 2022; McKendy *et al.,* 2021). Prison staff spending long periods of time in coroners' courts consequently further depletes staffing resources (Banwell-Moore *et al.,* 2022), with inquests are often viewed as creating 'more stress than the incident' (McKendy et al., 2021: 10). Two papers address the experiences of prison healthcare staff attending coroner's court: firstly, a 'viewpoint' paper, outlining the limited international literature on clinicians as witnesses at coroners' courts (Wright *et al.,* 2012). Secondly, a broader paper explores the experiences of 'public safety personnel' - a category that included prison healthcare workers, around two potentially psychologically traumatic events, one of which is a 2019 Canadian prison death (Ricciardelli *et al.,* 2022). The authors themselves describe their work as 'limited… experientially acquired knowledge', drawn from 'informal and formal conversation rather than an empirical study', and argue that further study is needed in this area (Ricciardelli *et al.,* 2022: 6). There is a research lacuna regarding prison healthcare staff's experiences as witnesses in coroners' courts and the personal and/or professional implications of appearances. This thesis speaks to this research gap.

Chapter 3: Research, design and practice

3a) Introduction

This chapter sets out the methodology and methods used for this PhD study. It outlines the ontological and epistemological frames of the thesis: in summary, processual ontology, conceptualising the world as dynamic, giving 'full reality to relations and becoming' (Renault, 2016: 22) and a congruent interpretivist epistemology. From these ontological and epistemological underpinnings, the literature review and identified research gap informed the research questions. These were:

Primary research question

What are the impacts of encountering prisoner suicide and self-harm on prison healthcare staff?

Secondary research questions

a) What are the *initial* narrated impacts of encountering prisoner suicide, self-harm and/or repeated self-harm on prison healthcare staff?
b) What are the *enduring* narrated impacts of encountering prisoner suicide, self-harm and/or repeated self-harm on prison healthcare staff?
c) What are the impacts of *cumulative* exposure on prison healthcare staff, including on their responses to prisoner self-harm and suicide attempts?

The chapter discusses the choice of qualitative methods to address the research lacuna and for ontological and epistemological fit; acknowledging most extant work about staff working with suicide and self-harm in prison and analogous settings, is quantitative and therefore less able to deal with the nuance of staff experience and implications for practice (Dennard *et al*., 2021). The planning phase of research is outlined before consideration of data collection itself, 28 semi-structured qualitative interviews, and the processes of analyses using reflexive thematic analysis. Finally, the limitations of the study are explored and information about the presentation of the data is provided.

The research questions steered the choice of research method, interview design, data collection and subsequent analysis. To further understand the complexities and nuances of healthcare staff responses to prisoner suicide and self-harm, as posed by the research questions, a qualitative method was chosen. Qualitative approaches emphasise 'meaning as contextual or situated, reality or reali*ties* as multiple, and researcher subjectivity as not just valid but a *resource'* (Braun *et al.,* 2019: 848, emphasis in the original). Qualitative methods 'are dynamic and capture emergent meanings' (Bosk, 2014), demonstrating their congruence, feasibility and usefulness within the ontological approach adopted and as a fitting method for the methodology. Additionally, given the sensitivity of the topics data collection sought to probe, e.g. personal experiences and responses to self-harm and suicide, qualitative research methods can play an important role in helping participants to 'develop and express their own reality' (Dickson-Swift *et al.,* 2008: 7). Prisons are often hidden from public consciousness (Podmore, 2012). Therefore, prison healthcare staff may have experienced things that a wider audience may not have access to easily. Being able to share such experiences, even in the context of a qualitative interview and having your words listened to, can erode the experience of hermeneutical marginalisation (Fricker, 2018). This qualitative method with this thesis' methodology contributes to an expanded epistemology of prisons, which creates opportunities, is helpful and hopeful, and much needed given the ongoing prison crises.

3b) Ontology

Ontology concerns the question 'what kinds of things are there in the world?' (Benton and Craib, 2011: 4). Within social sciences, it concerns the nature of social reality/ies (Delanty and Strydom, 2003) and there is ongoing debate regarding 'what the constituents of the social world are', with theorists grouping ontological schools of thought in different ways, e.g. by philosophical underpinnings (Benton and Craib, 2011: 5). This thesis rejects positivist ontologies that posit social reality as singular, 'a perpetual entity… that can be observed' (Delanty and Strydom, 2003: 6). It uses processual ontologies that conceptualise the world as 'making, remaking and unmaking itself (and other things), instant by instant' (Abbott, 2016: ix). The roots of processual ontologies are found in: the Hegelian concept of energy and 'reciprocal action' (Hegel, 2010: par.142); Whitehead's contention that the 'actual world is a process… it's being constituted by its becoming' (Whitehead, 1929: 31); and Dewey's

'interaction' and 'transaction', that is the vibrant shifting between interconnected elements (Dewey and Bentley, 1995: 97-110). Processual ontologies foreground the dynamic nature of relationships and relations, and 'the idea of process denotes the fact that the mutual activity has the power to modify the properties of the elements as well as the form of relation that shapes this mutual activity' (Renault, 2016: 21). They can be summarised thus: 'the emphasis is not so much on reality that is becoming, but becoming that is real' (Nayak and Chia, 2011: 282). Within these ontologies, power is no longer only located in or between fixed persons and institutions, it is 'able to "jump" across scales rather than operating through state-centric hierarchies' (Tomczak 2022a: 497). The movement and evolution inherent in this ontological approach recognises that significant changes can occur without relying on macro or structural shifts.

This approach is well-suited to the thesis' research questions: it can engender novel, dynamic thinking across scales – e.g. domestic, national, international – to tackle prison suicide and self-harm (Tomczak, 2022a). Scholars have critiqued processual ontologies, their hyper-contingencies and focus on becoming, as idealistic, e.g. Dawson and Buchanan, 2005. I contend that using this approach, rooted in emergent, evolving possibilities that could be realised through a variety of (f)actors is *particularly* helpful for urgent crises in apparently intransigent systems. Appropriately, the word emergency, contains the word emerge (Solnit, 2004). For example, Bai *et al*. (2021) used processual approaches to think and frame responses to ecological disasters differently, eschewing anthropocentrism and atomised approaches for a 'dynamic holism, in which everything is interconnected and in flux' (Bai *et al*., 2021: 694). This suggests the primacy of connection and movements in processual ontologies is useful in evoking alternatives to neoliberal punishments and prisons, which seek to individualise and reify inequalities (Wacquant, 2009b). These processual ontologies can also allow for 'new kinds of reflection on uneven power relations', e.g. between prisoners and prison healthcare staff, as they make explicit the processes that are contributing to, but that could also change, power relations (Grove and Pugh 2015: 12). Historically, rule-based ontologies have been common in the conceptualisation of Western prisons, scholars now suggest 'prisons are relational and constituted by power in practice: determined not only by statist legal regimes but also by social, cultural, and economic dynamics' (Kemp and Tomczak, 2023: 19). The emergent and contingent nature of processual ontologies accommodates one of the core

assertions of this project: that prisons are porous (Ellis, 2021; Martin and Jefferson, 2019), rather than closed institutions (Goffman 1961), and that therefore prison health is public health (Dumont *et al.*, 2012; Link *et al.*, 2019). Liebling's (2019) states humans are 'irreducibly socially constituted', drawing on social theorist Christian Smith's ideas of 'emergent personhood', and that working with prisoners as emergent people can be 'transformational' (Liebling, 2019: 204). The research questions, considering the experiences of and impacts on prisoner healthcare staff of prisoner suicide and self-harm, are grounded in relationships between emergent persons. They probe how this cohort of staff responded, at the time and over time, to the prisoners that they relate to at work. The research questions stem from the premise of the porosity of prisons and acknowledge the dynamic, through-the-gate nature of the impacts of the potentially traumatic experiences staff have. The secondary research questions concerning the initial, enduring and cumulative impacts of this work create space for the emergent nature of responses to these events, over time, recognising impacts may change, contingent on variables - e.g. environment, external life events, mood - on any given day. These secondary research questions, combined with this ontological approach, assist the exploration of the complex emotional and practical terrain of experiences, responses to and impacts of prisoner suicide and self-harm. Adopting this ontological approach embraces experiences which are remaking realities continuously, thus enabling new theoretical possibilities and findings which are sorely needed to address the chronic prison crisis.

3c) Epistemology (including researcher positionality)

Where ontology concerns the nature of the things to be studied, epistemology is concerned with the 'possibility, limits, origin, structure, methods and validity (or truth) of knowledge' (Delanty and Strydom, 2003: 5). This thesis uses an interpretivist epistemology, which is appropriate to deploy alongside processual ontologies, as both allow for the intersubjective, complex and contingent *nature of things* (ontology), as well as the intersubjective, complex and contingent *how* and *from who* we come to know them (epistemology) (Creswell and Creswell, 2018). An interpretivist epistemological stance seeks to understand and not just explain social action (Weber, 1947) and acknowledges the study of people requires accepting the 'subjective meaning of social action' (Bryman, 2012: 30). The potential meanings of social action are myriad and diverse, dependent on individual and collective interpretations of them.

This thesis rejects a positivist approach to epistemology, that is approaching experiences of suicide and self-harm with natural science methods and rejects the epistemology of objectivism and ideas of discoverable objective truths (Crotty, 1998). It rejects these because of their incompatibility with the chosen ontological approach. Positivism cannot account for multiplicity or subjectivity, nor can positivism sufficiently answer the research questions posed, particularly in navigating the nuance and intricacy of the topic (Bryman, 2012). The usage of processual ontologies and interpretivist epistemology has been demonstrated to be methodologically and practically feasible in existing scholarship: e.g. Sergi and Hallin (2011); Skinns *et al.* (2017); Tomczak (2014). This thesis is an inductive study, generating theory from qualitative data and with an emphasis on individual meaning, that allows for nuance (Creswell and Creswell, 2018). An inductive approach reinforces the ontological and epistemological positions adopted for this PhD.

Researcher positionality

Part of the epistemological landscape is the positionality of the researcher. Here follows a précis of my experiences as relevant to the research questions. My experience of prisons in England and Wales is largely as a worker. A few of my friends have been imprisoned and I have been to prison to visit them, but this is not my primary engagement with the justice system and prisons. Between 2008 and 2014, I worked one day a week in a women's prison for a voluntary sector organisation, as a subcontractor to the NHS Trust who held the prison's healthcare contract. I also worked in a wider range of prison and justice settings in other roles between 2011 and 2018. As such, there is an element of "insider" in my researcher positionality. Historically, insider researchers were considered to have an a priori significant knowledge of a community (Merton, 1972). This understanding has evolved over subsequent decades with scholars advocating an insider-outsider continuum (Hellawell, 2006; Mikecz, 2012) or acknowledging a fluidity and duality of position as both insider and outsider (Wilkinson and Kitzinger, 2013). Being perceived as an insider researcher may assist data collection, making it easier to garner trust and show empathy (Gair, 2012). In this study, by the commencement of the fieldwork four years had passed since I had worked in a justice setting and it eight years since I had worn an NHS lanyard or had an NHS email address. Therefore, by original definitions, this was not strictly insider research but my experiences of working in prisons and in prison healthcare informed the research design and data collection.

That is, my tacit knowledge, my 'intuitions, apprehensions and feelings' that arose from and built on my lived experience, informed and enabled my research endeavours (Guba, 1981: 78; see also Lincoln and Guba, 1985). Given the ontological and epistemological frameworks employed here, fluidity and complexity within the insider-outsider continuum, rather than dichotomy of insider/outsider researcher positionality was apt. Indeed, 'similarity and difference are neither unitary nor fixed categories; they can be partial, and they can shift across the course of a research project' (Wilkinson and Kitzinger, 2013: 251). In this study, some residual tacit knowledge of prison healthcare work remained, but time and the role of post-graduate researcher distanced me from being a contemporaneous insider researcher.

I also wish to acknowledge another aspect of insider positionality within this research: I worked with prisoners who self-harmed and who attempted suicide, but no-one I worked with completed suicide. Part of my interest in this subject is because of my own experiences and the unanswered questions they raised. One day, early on in my prison work journey, I walked into a wing common room and found someone momentarily suspended by ligature from the pipework. Fortunately, they were swiftly cut down before they lost consciousness. That experience and its aftermath provoked my further interest in the subject of suicide in prisons, its prevention and the impacts on other prisoners and staff, as well as on the suicidal person. I have been bereaved by suicide three times, so although I have not experienced workplace bereavement by suicide, I include myself as someone with lived experience of suicide bereavement. I include these personal experiences to recognise their shaping of this thesis and to aid the reader in placing me on the insider-outsider continuum.

3d) Research planning

3d.i) Research questions

At the inception of the PhD the primary research question was:

What are the impacts of encountering prisoner suicide and self-harm on prison healthcare staff?

This question assumed that suicide attempts could be included with the self-harm findings and acknowledging the grey area of overlap between self-harm and suicide attempts. Having completed the study and noted the prevalence of attempted suicides with profound effects on staff, a more accurate primary research question would be:

What are the impacts of encountering prisoners' attempted and completed suicide and self-harm on prison healthcare staff?

Following a review of the literature and the identification of a gap as to how suicide and self-harm effect staff over-time and as experiences accumulate, the secondary research questions were developed, they are listed in full at the start of the chapter and pertain to the initial, enduring and cumulative impacts on staff, as well as the impacts of these impacts. These research questions were used to steer the choice of research method, interview design, the ensuing data collection and subsequent analysis.

3d.ii) Choice of research method

The research design for this thesis flowed from the ontological framework, interpretivist epistemology, the research questions posed and the proposed inductive approach to data gathered. Processual ontologies posit that research is a 'rich, complex and multi-level experience' (Sergi and Hallin, 2011: 192), and that findings do not simply describe concretely and finitely the world as it is but can be emergent, creative and continually developing (Revsbæk and Simpson, 2022). Phase one of the research comprised a literature review which then informed the identification of research gaps and aided the creation of secondary research questions (Bryman, 2012). There are data and statistics available on prisoner suicide and self-harm readily available in the public domain – e.g. *Safety in Custody quarterly reports* (Ministry of Justice, 2024a) – but these do not help explore the experiences, except in terms of volume across the estate, of prisoners or staff. There are also Prisons and Probation Ombudsman (PPO) Fatal Incident Investigation reports, which make recommendations to individual prisons following prisoner deaths. The PPO investigate all deaths in prisons but has no statutory footing. The reports and recommendations take little account of the socio-economic and/or system wide factors, nor the impacts of policy, e.g. the deleterious impacts of reducing prison staff numbers via bench-marking in 2012 (Peacock *et al.,* 2018). The PPO

use a model that focuses the role of individuals, rather than the systems within which they operate, leading to many repeated recommendations, meaning the PPO 'struggles to effect change' (Tomczak and McAllister, 2021: 216). These PPO reports may provide a degree of illumination as to the staff experiences, but their purpose is not to understand things from a prison staff perspective.

Dennard *et al.* (2021) note that predominantly quantitative methods have been used, for example self-report questionnaires, with staff groups exploring prisoner suicide and self-harm, e.g. Bell *et al*. (2019), Isenhardt and Hostettler (2020), and Lambert *et al*. (2012). In this study, quantitative, remotely administered questionnaires would not provide nuance nor elicit the thick, descriptive data sought by the chosen method (Dennard *et al*., 2021; Geertz: 1973). Qualitative interviews have been used by some researchers into prison suicide and self-harm, e.g. Liebling (2012), Ludlow *et al*. (2015), Walker *et al.* (2017), demonstrating the validity of this method here. This study builds on this scholarship to create an original contribution by focusing on prison *healthcare* staff and including management and elite interviews. Unusually, it covers a wide range of prisons, in terms of geography and category. A qualitative approach in sensitive research aids people to 'develop and express their own reality' (Dickson-Swift *et al.,* 2008: 7). It was therefore chosen to give maximum opportunities to understand more fully the experiences of and subsequent impacts on these prison healthcare participants. This also provides the opportunity to expand prison epistemology and reduce the hermeneutical marginalisation of healthcare staff. With the sensitive subject matter, focus groups were not appropriate; this also protected participant confidentiality. Semi-structured interviews are suitable to address research gaps, to garner novel, rich data and also, for sensitive subject matters (Bryman, 2012; Corbin and Strauss, 2015). They allow the researcher flexibility, so the 'content and flow of questions can be altered to probe for deeper meanings when required' (Webber-Ritchey *et al.,* 2021: 14). Semi-structured interviews were also chosen to facilitate participant autonomy as they retold potentially difficult experiences. This enabled the participant, not just the interviewer, to move on or dwell on a particular section of the interview schedule. Therefore, this genre of qualitative interview was the best fit.

3d.iii) Changes to research design because of the Covid-19 pandemic

The thesis I originally proposed to undertake at the University of Nottingham from Autumn 2020 included approximately 64 in person interviews with serving prison healthcare staff over eight prison sites. During the first term of study, it became clear the pandemic would have ongoing impacts on prisons for some time. Before undertaking research in prisons, scholars apply to the HMPPS National Research Committee (NRC) for permission. During the pandemic, the committee implemented strict guidance with a moratorium on research in prisons. The committee also stipulated a phased return for research, which prioritised internal Ministry of Justice and HMPPS research, with academics in a much later phase. Understandably, the HMPPS NRC could not propose a timeline to go with the phases of research return. In such uncertain circumstances and to prevent uncontrollable and unquantifiable delays to data collection, the supervisory team and I decided to pivot to data collection with *former* prison healthcare staff. This had the benefit of widening the cohort of potential participants and collecting data from a broad range of experiences, public/private/third sectors, job roles and geographies. It also meant that the former healthcare staff were not speaking from the intensity of sustaining themselves on the frontline during a pandemic, and enabled greater reflection and reflexivity in contributions. There were some limitations resulting from the pivot to former staff. The breadth of recruitment criteria may mean potential findings are harder to discern, given participants may be narrating experiences from very different times in prisons, e.g. when they were healthcare officers, not under an NHS or healthcare contract. Another limitation was the inability to visit and spend time in the institutions participants worked in or gather observational or ethnographic data there. With this revised remit to interview former staff, the recruitment of participants was planned from several starting points: my former work networks, the use of gatekeepers, and snowball sampling (Johnson, 2014). Alongside former prison healthcare staff, I planned to recruit participants who were specialist knowledge stakeholders, e.g. participants who had deep expertise through their involvement with specialist bodies or boards, as prison health consultants and/or as voluntary sector leaders. The final cohort for recruitment were prison healthcare management staff, to potentially provide strategic insights into the impacts on staff cohorts of prisoner suicides and self-harm. Choosing these three cohorts of under-researched people enabled the project to be more reliably planned whilst retaining the same research questions, even within the restrictions of a pandemic.

The other main consideration was to pivot to remote synchronous data collection, that is interviews 'mimicking real-time, face to face conversations' via the use of MS Teams and phone calls, rather than on site and in person (Bouchard, 2016: 61). This was necessary because of the pandemic and the University of Nottingham research ethics committee requirement that qualitative interviews use remote rather than face to face interviewing. To compensate for what might be considered lost through remote interviews, the intention was set to start MS Teams interviews with my camera on. For phone or MS Teams interviews, there would be some introductory small talk to aid with rapport building (O'Connor *et al.,* 2008) and to mitigate the loss of 'embodied care' that can be demonstrated to participants in person (Carter *et al*., 2021: 714). I chose to offer the option of a telephone or MS Teams call to assuage any potential exclusionary effect of using an online-only modality (Carter *et al.,* 2021). Previous studies dealing with sensitive material have used audio-only interviews (usually by telephone). They have been recognised as a valid and valuable means of data collection when working with participants who have experienced trauma (Trier-Bieniek, 2012), by helping to minimise the potential for psychological harm and risks to participants associated with sensitive research (Mealer and Jones, 2013). Given the 'potentially psychologically traumatic events' (McKendy *et al.,* 2021: 2) that were part of data collection, offering participants an audio-only option, e.g. by phone or with camera off, was useful and valid.

3d.iv) Research design

A narrative literature review was undertaken as the first phase of this study. A narrative review is 'an overview of a field of study through a reasonably comprehensive assessment and critical reading of the literature' (Bryman, 2012: 102), as appropriate to my interpretivist epistemology. This included: searching on databases, e.g. Google Scholar, hand searching bibliographies of articles and attention to relevant grey literature. The literature was then grouped in four cohorts to review, these were:

i) prisoner self-harm scholarship that includes prison staff perspectives
ii) prisoner suicide scholarship that includes prison staff perspectives
iii) scholarship from parallel settings about staff encounters with workplace self-harm
iv) scholarship from parallel settings about staff encounters with workplace suicide

Literature on staff responses to self-harm and suicide in parallel workplaces enriches the scant information regarding healthcare staff responses in prison. In groups i) and ii) studies were included across all types of prison staff, that concerned staff interactions with and responses to prisoner self-harm and/or suicide. Section iii) included papers that dealt with encountering self-harm and, section iv) suicide, in the workplace, some of which are within parallel settings, e.g. secure psychiatric units; and the remainder of which is first responder literature, e.g. ambulance crews, fire fighters, law enforcement officers. The review only included papers in the English language. It included papers dealing with jurisdictions other than England and Wales due to maximise understanding. The review helped signify existing themes, identified the research gaps and provided the foundation for data collection, namely shaping the interview guide.

Phase two of the research project was qualitative data collection via semi-structured interviews. The research schedule was developed based on the research questions and to explore research gaps highlighted by the literature review – please see Appendix 2 for the research schedule used. The schedule was used to *guide* discussions with participants, as appropriate for semi-structured interviews. The schedule was organised carefully, beginning with initiating and contextualising questions before moving onto more focused questions concerned with the core subject matter (Rubin and Rubin 1995) and in concluding the interview, had a "winding down" section (Andriessen *et al.,* 2018), to enable the participant to decompress somewhat and regain composure, if necessary (Ashton 2014). Alongside the interview schedule, I wrote a short list of questions to consider post- interview (Appendix 3), which created researcher reflections. These can be of use in research dealing with potentially sensitive and emotional subject matters, not least to enable greater reflexivity and understanding of researcher subjectivity (Valentine, 2007). Given the possibility for distress inherent in the research, I created a Participant Distress Protocol (Appendix 6) based on the Nicholson Distress Protocol to minimise any potential distress to the participant, which including pausing or terminating the interview. I created a plan in the unlikely event of disclosure of current or intended harm to self or others, which was laid out in the participant information sheet and the participant consent forms and complied with the directions in the University of Nottingham Code of Practice for Research Ethics Committees (CoPREC) guidance. These documents were the core research tools prepared ahead of data collection.

The overall sample size needed consideration. Predicting the number of interviews at which data saturation will occur is an often used for suggesting participant numbers. Data saturation originally comes from Glaser and Strauss (1967) who developed it as part of their Grounded Theory approach, using the term thematic saturation for when 'all relevant conceptual categories have been identified, explored, and exhausted' (Hennink *et al.,* 2017: 592). However, saturation is applied to a wider range of qualitative research paradigms and shifted emphasis to sample size rather than the quality of the data: which is problematic (Kerr *et al.,* 2010). Braun and Clarke (2021) further problematise data saturation and predetermining this ahead of analysis when using *reflexive* thematic analysis. They explore terms from other scholars that may provide a more appropriate fit for reflexive qualitative analysis, Dey's (1999) theoretical sufficiency or Nelson's (2016) conceptual density. Braun and Clarke compellingly argue, 'theoretical saturation is as much, or even more, about the *quality* of data collected – their richness, depth, diversity and complexity, what can be glossed as data or sampling adequacy – as it is about simply the *quantity* of data collected' (Braun and Clarke, 2021: 202, emphasis in the original). They also acknowledge that for pragmatic reasons, e.g. an ethics application, researchers may need to outline numbers ahead of data collection. Hennink *et al.* (2017) suggest nine interviews are sufficient for, what they name, coding saturation; this corroborates Guest *et al.'s* (2006) work. Hennink and colleagues then argue that meaning saturation requires 16-24 (or more) interviews, 'to develop a richly textured understanding of those issues' (Hennink *et al.,* 2017: 607). Based on discussions with supervisors, 30 participant interviews were proposed. The number of participants for each cohort was determined by the predicated availability of each group. These cohorts, with their proposed numbers of participants, were:

1) *Former prison healthcare staff who have left prison work* n ~ 15

2) *Specialist knowledge stakeholders (people with extensive professional experience re: prison healthcare, e.g. Voluntary and Community Sector (VCS) organisation leaders)* n ~ 8

3) *Senior managers who oversee prison healthcare for their NHS Trusts/* n ~ 7

private company/ VCS organisation

There were parameters set for inclusion and exclusion in the study across cohorts.

Cohort one, former prison healthcare staff	
Inclusion criteria	Exclusion criteria
1) *have worked in a prison in either England or Wales* 2) *within this study prison healthcare staff include primary healthcare workers, mental health staff, voluntary sector organisations, agency or bank staff, specialist staff such as dentists or substance misuse nurses, staff of any grade or banding within healthcare* 3) *they have had first-hand experience of prison suicide or suicide attempts or self-harm* 4) *must have a good level of spoken English.*	1) *healthcare staff currently working in prisons* 2) *healthcare workers who have not worked in a prison* 3) *prison healthcare workers from jurisdictions other than England and Wales* 4) *former prison staff who had no healthcare remit or association* 5) *people who worked in a peer to peer capacity within prison healthcare or who have left prison as a prisoner in the last three years.*

Table 1

Cohorts two and three, specialist knowledge stakeholders and senior managers	
Inclusion criteria	Exclusion criteria
1) *have a longstanding connection to and in-depth knowledge of and/or expertise in prison healthcare in England and Wales* 2) *have a longstanding connection to and in-depth knowledge of and/or expertise in*	1) *people with expertise only from jurisdictions other than England and Wales* 2) *those whose expertise is prior to 2017 (i.e. five years or more out of date). This*

prison suicide and self-harm in England and Wales *3) have contemporary knowledge of the subject matter* *4) have a good level of spoken English.*	*date range is given as for cohort two they needed to be contemporary specialists* *3) people with prison knowledge or expertise not related to the areas of prison health, suicide or self-harm.*

Table 2

These cohorts were drawn from different parts of the prison healthcare hierarchy, including elite stakeholder interviews (cohorts two and three), with groups not included previously in academic research concerning prison suicide and self-harm. Conducting elite interviews, that is interviews with those with 'close proximity to power' (Lilleker, 2003: 207), in a raised position within social structures (Stephens, 2007), provided opportunities for strategic insights about the implications and impacts of suicide and self-harm for frontline staff. Elite interviews can be essential sources of information in the fields of public policy or power relations (Natow, 2020), both relevant to this thesis. The managerial and specialist knowledge stakeholders had long-term and ongoing knowledge of individual prisons and of wider relevant trends. Former prison healthcare staff brought lived experience perspectives from delivering healthcare and dealing with self-harm and suicide. Collectively, these three cohorts enabled data collection from a broad range of perspectives, helped to develop well-rounded insights into phenomena (Patton, 1999) and enhanced understandings of these urgent yet enduring issues.

Sampling was purposive and recruitment was planned via personal networks and using existing gatekeeper contacts to help to identify potential participants. Gatekeepers are often used in social science research to access cohorts of participants for researchers (Singh and Wassenar, 2016) and can be 'instrumental in allowing… access to participants' (Spacey *et al*., 2021: 432). Via my networks and those of my supervisors, I accessed four gatekeeper contacts, still working in prison health, who were happy to contact those they knew who had left prison healthcare about possible participation. There was also an intention to use snowball sampling if more participants were needed, given the sensitivity and potential wish for anonymity

within the cohort (Parker et al., 2020). This was a practical response to the restrictions of the pandemic and a feasible approach from my ten years working in criminal justice settings. Potential participants would be sent an introductory email or message, asking for an indication of interest or otherwise in participating; once contact was made, all recruitment would then take place by email via a University of Nottingham email account. Potential participants would then be sent the full Participant Information Sheet (see Appendix 4). After confirmation of participation, the participant would be sent the Participant Consent and GDPR form (Appendix 5) and given the opportunity to ask any questions, before they were booked in for interview at a mutually convenient time. In the case of identifying former prison healthcare staff, the plan included use of newsletters to professional groups and social media, should there not be enough participants coming forward.

As previously noted, due to the pandemic, the interviews were to take place entirely via MS Teams or telephone during 2022. Interviews were to be recorded on MS Teams and then transcribed using the University of Nottingham Automated Transcription Service, in compliance with GDPR and to meet the data confidentiality standards laid out by the School of Sociology and Social Policy research ethics committee. Following transcription, the transcripts would have any identifying data removed. All study data, e.g. interview transcripts, would be stored on my University of Nottingham OneDrive, in a Teams channel, and deleted after seven years.

3d.v) Discerning, applying for and receiving ethical approval

Having decided on the three cohorts of potential participants, which ethical approvals were needed and from whom were determined during the summer and autumn of 2021. Had I still been working with current prison healthcare staff, there would have been an application to both HMPPS National Research Committee (NRC) and to the Health Research Authority (HRA), via IRAS (Integrated Research Approval System). Because I was not researching serving healthcare staff, HMPPS NRC approval was not required. Regarding healthcare ethical approval, this was more complex to determine. I consulted the written guidance available to University of Nottingham scholars about HRA approval and understood that neither cohort one (former prison healthcare staff) nor cohort two (specialist knowledge stakeholders) required HRA approval. I contacted the University of Nottingham sponsor to gain clarity on

whether an HRA application was necessary. She advised, 'if any NHS resources or systems are used to identify the staff then you need HRA approval in place' (pers. comm., 2021). Therefore, I concluded that the only ethical permission required for these two cohorts was that of the University of Nottingham School of Sociology and Social Policy (SSP) Research Ethics Committee (REC). I submitted to the University of Nottingham SSP REC in November 2021 for these two cohorts, to prevent delays. I received a favourable ethical opinion from the committee in December 2021, allowing me to commence recruitment. The participation of cohort three – senior managers – some of whom would still be working for the NHS, required more clarification. In further communication with the University of Nottingham Sponsor's Office, she stated, 'When recruiting using professional/personal networks and snowballing methods etc then our advice is that you can proceed with University ethics only' (pers. comm., 2021). It was also made clear that the research findings should not name any NHS trust or individual prison; this presented no problem, as this had already been stipulated in the submitted ethics application. After this thorough consideration, I submitted an amendment to the University of Nottingham SSP Research Ethics Committee, to include this third cohort of senior managers in February 2022 and received an updated favourable ethical opinion, allowing their inclusion in data collection.

3e) Data collection

3e.i) Data collection: recruitment and final sample

I began recruitment in January 2022, using professional networks and accessing gatekeepers to provide access to other potential participants. I also used snowball sampling, commonly used for 'hard-to-reach populations' (Parker *et al.,* 2020: 2), when participants indicated they were willing to assist with their networks. Recruitment proceeded as outlined in the section above. Recruitment began well and I undertook 18 interviews between mid-February and mid-May 2022. I took some time away from interviewing to complete my Year Two annual review and the resumed recruitment efforts from late June 2022, undertaking another 10 interviews between July and September, resulting in 28 interviews in total. Recruitment for the second tranche of interviews was harder. I used social media and revisited previous participants to ensure any possible participants had been contacted. I received several

requests to participate from serving prison healthcare staff, which had to be declined but demonstrated interest in the subject matter and the need for future research with serving staff. The final sample recruited was:

1. *Former prison healthcare staff* *n ~ 15*
2. *Specialist knowledge stakeholders* *n ~ 6*
3. *Senior managers who oversee prison healthcare for their NHS Trusts/ private company/ VCS organisation* *n ~ 7*

Participants' length of work experience varied from ten months to 33 years in prisons. Only one participant worked less than a year, five had worked 2-5 years, ten worked 5-10 years, with 12 participants having worked for 10 years or more in prisons. These are far longer than most prison average healthcare careers. Several participants had previously worked or gone on to work in allied services such as acute mental health or community substance misuse services, so considered their expertise of a longer tenure than just their work in prison settings suggested. Roles held by participants included frontline roles such as: healthcare assistant, registered general nurse, mental health nurse, GP, psychologist, counsellor. Also represented was a range of management and consultancy roles, many of whom had previous frontline experience prior to their senior trajectories to roles such as professor, clinical director, commissioner. During the course of data collection, participants named 48 different prisons that they had worked in, although even more prisons were represented in the research, e.g. having oversight of healthcare in tens of prisons, another participant had had a 26 year career, including bank work at a range of prisons and a regional oversight role over numerous prisons. The prisons participants worked in covered the male and female estate, public and private prisons and represented healthcare teams that were run by the NHS, private and third sector providers. The sampling used was purposive sampling and snowball sampling, which does not give a representative sample and data that is generalisable across all prison healthcare in England and Wales. However, it is a strength of the data collected that the coverage of the estate in England and Wales was significant and the inclusion of so many institutions therein adds rigour to the findings.

3e.ii) Data collection: the interviews

The interviews lasted between 38 minutes and 88 minutes. In the introduction, participants were informed the interviews were up to an hour, timing as required. When an interview approached the c.50 minute mark, I would discuss with the participant the remaining time, if there were still things to cover I could move the interview on as appropriate. At this point, several participants indicated a willingness to stay longer than the suggested hour because there were still contributions they wanted to make. Given the nature of the content of the interviews, I set a personal boundary of 90 minutes for the interviews, which worked well. There were five interviews that lasted 70 minutes or more. The shortest interview was an outlier and an interview with someone who had only ten months experience working in prisons and had limited experience working with prisons who were suicidal and who self-harmed. Most interviews, 22 of them, lasted between 55 and 66 minutes, forming the median group of interview lengths.

Once participants were confirmed, I offered a wide range of times for interviews and asked participants to suggest other times, should those not work, aiming to reduce barriers to participation. Being available and flexible with interview times is particularly important with elite interviews (Mikecz, 2012; Stephens, 2007). Interviews took place at a variety of times, the earliest being 0800 and the latest starting at 1745, to fit best with the participants' schedules. All except one interview took place on a weekday, with one elite interview taking place early one Sunday morning, to enable the least interruptions for that participant. Scheduling at times was challenging, with some interviews arranged many weeks in advance of them taking place. This experience demonstrated an advantage of remote interviewing: it was far easier to rearrange interviews at the participant's request, with less consequence for travel plans and other logistics. Due to the potentially distressing content, I aimed to space interviews out 'to reduce risk of emotional exhaustion', to allow time for other work activities during the week (Dickson-Swift *et al.,* 2008: 118). On two occasions, I undertook two interviews on one day but the majority of the data collection was staggered appropriately, to allow reflection and recovery, as needed.

Conducting sensitive interviews remotely

As noted earlier, these interviews were required to happen remotely rather than face to face due to pandemic-related research restrictions. The remote nature of the interviews was

imposed, but studies suggest that online interviews can be particularly helpful with sensitive subject matter, due to 'increased perceived anonymity' (Wilkerson *et al.,* 2014: 564). Five participants confirmed that they would prefer a phone call rather than a MS Teams meeting. One participant was explicit that, because of the anticipated content of the interview, they wanted to be outside walking whilst the interview was conducted, so the phone was preferred. This demonstrated an advantage of offering phone interviews for sensitive material: the participant chose the setting in which to recount potentially traumatic material. 23 participants opted for a MS Teams call, one of which reverted to phone during the interview due to technical difficulties. Six people conducted the interview with their cameras off and 17 conducted the interview with their cameras on. Participants when asked at the start of the interview about having the camera on or off, usually deferred to me as interviewer and I had to ask them again what they would prefer. Replies like this were typical,

> *'Doesn't make any difference... keep it on?'*
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

The nature of MS Teams is usually with a visual, so participants mostly came to the interview conversation with the expectation of being seen. One tactic to aid rapport building in sensitive interviews, is to mirror the participants communication style (Minichiello *et al.,* 2000). Within this study, I extended that to include keeping my camera on or off in congruence with whatever the participant did. There were four interviews where there were issues with the technology, two of which were when my MS Teams was malfunctioning and two of which were when participants' laptops were not sufficiently charged. The latter two interviews then happened in two halves. Only on one occasion did the second half have to happen on another day, a week later (at the participant's request), which interrupted the flow somewhat. Participants often chose to do interviews at times and in locations that minimised likelihood of disruption, e.g. before or after work, when they were at home and not on site. Collecting data in prisons can be influenced by 'meal times, work schedules, program activities, real or perceived security threats, disturbances, or lock downs… that might cause the research to be inhibited, delayed, or cancelled' (Patenaude, 2004: 87). Doing interviews remotely aided in the non-disturbance of interviews by external factors.

The sensitive content of the interview meant attention was given to concluding them well, especially given the remote rather than in person nature of them. The closing section of the interview asked participants how they had found the interview and provided a moment for pause and reflection, particularly where the content shared had been heavy. We then discussed what the participant was doing next or for the rest of the day, and, as necessary, how the participant might manage anything residual the interview had triggered, e.g. going for a walk, talking to a friend. Many participants then asked about timelines for my research or any emergent findings before we concluded and I reminded them of the confidentiality, that I would be emailing them some support phone numbers, should they be needed and to inquire as to whether they knew people who might participate in the research. Although immense sadness and regret was shared during the interviews, there was no disclosure of current or intended harm to self or others. After most interviews I wrote a short researcher reflection, using the questions in Appendix 3 as a guide. These reflections included practical notes when an audio recording would not capture something, e.g. when a participant made a gesture with their hands, and impressions or immediate reflections on the interview, e.g. feeling heavy or noting the speed of the speaker.

3e.iii) Recording and transcription

The final aspect of data collection relates to the logistics of recording and transcription. Recording was audio only, irrespective of the whether the interview was conducted with the camera on or off. This was to help with participant confidentiality and participant confidence in that confidentiality. I used the record function on MS Teams as audio only, I also made a back up recording on a dictaphone, that I deleted once I had the transcript back and could check that there were no issues with the quality of the recording. With such sensitive material, I wanted to take additional care to capture data and not need to revisit any interview because of recording problems. Transcription took place using the University of Nottingham Automated Transcription Service (ATS); the service is confidential and less costly than using external transcribers. As soon as possible following an interview, the audio file was converted to the necessary format, MP3, to enable it to be uploaded to the ATS. Transcripts then appeared within an hour of uploading the audio file and were saved to the University of Nottingham OneDrive. However, once I opened the first transcription document, I realised that I would need to manually check through each transcription. Depending on the volume

and speed of the participant, as well as their accent, the transcriptions were varied in their accuracy and needed thorough checking. I also removed any potentially identifying data at the point, this included but was not limited to: the names of people, prison names, locations or regions and high profile historical events, e.g. riots, prison closures. Transcripts took at least a day each to go through. This enabled me to familiarise myself with the data, to engage with and reflect on the data from a new perspective. It helped me to understand that an interviewer is doing many tasks simultaneously, e.g. time keeping, making sure topics are covered, caring for the participant, and therefore may not be able to appreciate the nuance and richness of some data at the time of collection. Data collected - audio files, transcripts and researcher reflection documents – were kept in a different online location (within University of Nottingham OneDrive) to all study materials to aid participant confidentiality. Overall, data collection contained unexpected challenges, e.g. recruitment, but resulted in 28 qualitative interviews, conducted over a seven month period that contained pertinent data therein.

3f) Data analysis

3f.i) Analytic method: thematic, iterative

Data was analysed using Braun and Clarke's thematic analysis, an approach which suits data generated by people's experiences, thoughts and perceptions (Braun and Clarke, 2006). In later work Braun *et al.* (2019) define three genres of thematic analysis: coding reliability, codebook and reflexive. Reflexive thematic analysis emphasizes the 'active role of the researcher in the knowledge production process' (Braun *et al.,* 2019: 848). It uses coding practices that are 'open, fluid, organic and recursive', codes 'evolve, expand, contract, be renamed, split apart into several codes, collapsed together with other codes and even be abandoned' (Braun and Clarke, 2021: 207). Themes – patterns of shared meaning - in reflexive thematic analysis develop from the 'analytic process following coding' (Braun and Clarke, 2021: 209). This genre of thematic analysis explicitly signposts its ongoing, fluid, emergent nature, for example, 'coding and deeper analysis do not inevitably reach a fixed end point' and 'codes are conceptual tools in the developing analysis and should not be reified into ontologically real *things'* (Braun and Clarke, 2021: 210 and 207 respectively). These factors

make reflexive thematic analysis a sound fit for the analytic work of this thesis and its processual ontological approach.

3f.ii) Analysing data together

The data gathered was rich, containing thick descriptions. I began coding transcripts whilst still interviewing and to prepare for my year two review, I analysed three transcripts from former frontline healthcare workers. Taking an inductive approach to the data means that the question of how to segment participants responses remained open (Bryman, 2012). Triangulating the three cohorts of participant data did not provide a sound ontological fit, as triangulation assumes a fixedness and a stability of reality, which the researcher is trying to unveil through approaching this singular reality via a variety of perspectives (Silverman, 2000). There was still consideration of whether to analyse the three cohorts of participants' data in three discrete groups, whether to analyse all 28 interviews together, whether to analyse the elite respondents as one cohort or to split the data another way, e.g. from segregating data into private, public (NHS) and third sector participants. Part of the difficulty of categorising the participants is that some had careers spanning many years and therefore, several roles within prison healthcare. Some had moved from one cohort to another, for example, one participant had previously been a prison Head of Healthcare and then a senior manager in an NHS Trust, then a senior manager in a private company that held prison healthcare contracts. They were interviewed not as part of the manager cohort but as part of the former healthcare staff cohort. The original primary research question - what are the impacts of encountering prisoner suicide and self-harm on prison healthcare staff? – made no distinction around cohorts of staff, so proceeding with analysis of the whole cohort emerged as the most suitable course of action.

I analysed the 28 interviews together but to allow the possibility of changing course and reverting to analysing the three cohorts of data separately, I allocated participants a letter of the alphabet – A, B or C – related to their cohort, as well as a number. A was for former healthcare staff, B was for the specialist expert stakeholders and C was for the senior managers. This meant once analysis had begun, should cohort specific patterns arise relating to staff experiences and their impacts, reverting to segmenting the data by participant cohort would be more straightforward. Generating codes and themes is reflective, iterative work

(Terry *et al.*, 2017). Therefore, I built a degree of flexibility into the segmentation of data. An additional benefit of analysing all 28 interviews together is that it allowed many job roles to be represented in one participant, e.g. when a senior manager had previously been a prison nurse. It also helped address data parity and mitigate the possibility of privileging one cohort of participants over another because of the richness and/or usefulness of their contributions. Retaining awareness of this issue regarding individual interviews was crucial.

3f.iii) Organising data for analysis

I began putting sections of data into word documents for later analysis, titles ranged from 'immediate impacts of prisoner suicide' to 'surveillance' and 'team work'. Some of these became 60 page documents and a few contained one or two quotes only. These documents served to manage data into smaller groups to be analysed. Documents that contained broad categorisations, e.g. findings related to prisoner healthcare staff experiences of self-harm, were then coded. In reflexive thematic analysis, coding is an 'organic and open iterative process' which can 'evolve throughout the coding process', in practice this means a code can be divided into more codes, renamed or combined (Braun *et al.,* 2019: 848). This was very much my experience as I visited and re-visited the grouping documents, different aspects of the transcripts struck me or at times, I found a more accurate word for a particular code or perceived that two codes were needed where I had thought one would do. This iterative, reflexive approach to coding serves to 'better capture the researcher's developing conceptualization of the data' (Braun *et al.,* 2019: 848). Given the research lacuna identified, I wanted some of the analysis to present participants' *experiences*, where these were similar to or divergent from other prison staff experiences of prisoner suicide and self-harm, before moving onto the *impacts* that these entailed. The earlier analytic chapters would therefore contain the experiences and initial impacts of working with prisoner suicides and self-harm. Codes were grouped and used to create themes. The language used for nascent codes and themes was descriptive and utilitarian; it iteratively increased in theoretical depth and rigour throughout thesis drafting.

3g) Limitations: including nature of data and sample set

Purposive sampling and gatekeepers were used in this study, as well as snowball sampling techniques. As such, the sample for this study is not a representative sample and does not claim to provide generalisable findings. People who opted to become participants in a study dealing with this subject matter may well have had greater exposure to prisoner self-harm than other prison or prison healthcare workers. Participants had far longer tenures than is usual in prison healthcare and therefore potentially more expertise. Participants often explicitly stated their own interest in both prisoner suicide and self-harm, as they sought its alleviation. An advantage of this sample is the potentially deeper understanding of prisoner suicide and self-harm than a randomised cohort may have provided. One participant split cohorts of prison staff into three, a group of which were:

> '*… amazing, absolutely wonderful people who were just like far nicer people, more patient than I could ever be in my whole life...'*
> Sullivan (A, former frontline VCS healthcare worker)

It seems likely that the people who were willing to give an hour of time to speak to a PGR prison researcher about prisoner suicide and self-harm, were drawn from this cohort: an idea explored again in Chapter 8: Pockets of Hope. A potential disadvantage of this is that staff with greater understanding of self-harm were less likely to stigmatise prisoners who self-harmed (Kenning *et al.,* 2010). One participant was an exception to this: their interview was the shortest and their main motivation for participation was to impress their former employer. It was a useful interview and retained as part of the study, given there were no exclusion criteria relating to participant motivations.

Other methods could be better suited to data collection from a more generalisable prison healthcare staff sample, e.g. Dennard *et al.*'s (2021) study which gathered 74 responses at a staff wellbeing event held in prison, thereby reducing barriers to participation. Asking for an hour of someone's time and the challenging subject matter may have prevented participation. Further work would be necessary to establish rates of prison healthcare staff exposure to prisoner self-harm and self-harm, to complement existing quantitative work on prevalence (Hawton, *et al.,* 2014; Ministry of Justice, 2023). In the context of a pandemic, with a moratorium on research in prisons, the choices made were pragmatic and enabled data

collection that was congruent with the ontological and epistemological underpinnings of the project. Another limitation of the data was the lack of current frontline healthcare staff represented within the sample. Further research may wish to address this, as well as considering whether a particular focus on a categorisation of prison may provide greater insights, e.g. Category B male locals, given this is where the urgent notifications and clusters of suicides most usually occur (Gov.uk, 2024b). Therefore, whilst noting these limitations of the data collected, these narrative findings illuminate the experiences of prison healthcare staff working with suicide and self-harm, the impacts on them and the implications for prisoners in their care.

3h) Presentation of data and terminology used

This thesis uses illustrative data quotes from participants. McKendy *et al.* note that their data quotes 'were slightly edited where necessary to correct grammar and spelling while preserving the tone and content' (McKendy *et al.,* 2021: 5). This thesis also adopts this approach to ensure ease of readability and comprehension. For example,

> 'the safer custody team did like an hour training for like all staff'
>
> Becomes
>
> 'the safer custody team did an hour training for all staff'

Throughout the text, when quoting from participants the use of ' […] ' indicates that the researcher has edited out some of the text. The use of '…' indicates that the participants themselves paused or their speech trailed off in the interview.

Throughout the text, italics are used to indicate emphasis in data excerpts. Unless otherwise stipulated, the emphasis indicated comes from the participant.

48 prisons were named by participants during the research. They were all allocated letters, e.g. Prison A, during the transcription phase of the study. This also would enable the identification of patterns across prisons or category of prison, should that be desired. Very few data in the thesis contain references to specific prisons, so these are re-named as Prison A, then Prison B and so on, based on the order in which they occur in this thesis, to minimise confusion.

Terminology used

Prisoner is used to describe those detained by the state and living in prisons. "People in prison" is not used as this thesis is primarily concerned with people who work in prison and such a term may cause confusion about *which* "people in prison" are meant. "Residents" is not used to describe prisoners, as whilst this may be a less stigmatising term, it erases the power dynamics and implies choice in residential location. I avoid terms like "offender" due to their negative connotations, forever binding that person to their offence which contradicts the thesis' ontological position. Criminologists commonly use the term "prisoner" (Crewe and Bennett, 2011; Liebling, 1992), although problematic and reductive because humans are always more than a label (Becker, 2018), this is a widely understood shorthand for someone who is presently incarcerated.

Suicide is used rather than "self-inflicted death" for several reasons. The term "self-inflicted death" is drawn from the language of official reports and therefore has a detached, clinical quality. This risks masking the individual and discrete loss of life, with the deaths becoming at statistic rather than giving attention to each person who has died in prison in this way. It is now accepted that 'a range of social, cultural and political factors contribute to suicide' (Fitzpatrick, 2018: 179). Therefore, the other risk with the term "self-inflicted death" is that, in keeping with the ontological and epistemological approaches of this thesis, rather than examining the contingent processes that may lead to a person's death by suicide, it simplifies it into an act undertaken by a lone individual. To use the term "self-inflicted" obscures this. It risks reinforcing the responsibilisation of the person attempting to die by suicide, thereby obfuscating the role of external factors, e.g. prison environment, public policies, health, mental health. However, the term suicide carries with it an understanding of intent (Durkheim,

1952; Tait *et al.*, 2015; Tomczak, 2018). This is hard to determine in practice, not least in prison settings where tying ligatures can be commonplace and when the motivations – even within one incident – can be confused and numerous (Walker and Towl, 2016). Therefore, using the term "suicide" is not unproblematic, it is more ontologically, epistemologically and philosophically congruent with content and values of the author and this thesis.

Self-harm is used to describe a wide range of phenomena whereby someone participates in events that include doing harm to themselves, recognising that a variety of factors may trigger this. There are ongoing debates about the correct nomenclature and definitions of self-harm, in part driven by divergent understandings of its meaning (Fox and Hawton, 2004; Ramluggun, 2013) and the complexity of conceptualising and examining it (Royal College of Psychiatrists, 2010). Although there is correlation between completed suicide and self-harm, some self-harm is motivated by non-suicidal factors, being e.g. a way to demonstrate distress (Hawton and James, 2005): therefore, it would be inappropriate to name it as "attempted suicide". I avoid pejorative terms like "self-mutilation". Within the term "self-harm", some definitions require the person undertaking the self-harm to be doing so 'purposely and consciously' (Patterson *et al.*, 2007: 1), but this is hard to determine, particularly in a prison environment. As with the term "self-inflicted death", there is a risk of nomenclature involving the word "self" to be reductive and obfuscating. As with suicide, self-harm is the outcome of myriad internal and external factors (Chandler, 2016). However, there is at present no other term widely used to indicate the complex genesis and journey of self-harm that does not include the term "self". Therefore, for accessibility and legibility, this thesis uses the term self-harm, as defined in the first sentence of this paragraph, recognising it is a socially contingent phenomena, rejecting responsibilisation and acknowledging that the responsibility for its perpetration and alleviation do not reside solely in the individual who is harming.

Chapter 4: Staff experiences of working with prisoner self-harm: pressure, paucity and pace

Please note: this chapter contains detailed descriptions of prisoner self-harm that readers may find distressing.

Introduction

As explored in the introduction, prisons are part of an overloaded justice system, struggling to meet the needs of those within it. Within this context, prison healthcare staff in this study narrated experiences of under-reporting of self-harm, that was greater in volume and in severity. This chapter contributes to knowledge with the following findings. The need for broader definitions of self-harm to encompass the range of ways prisoners may harm themselves, e.g. starting fights, here conceptualised as invited violence. Section 4b of this chapter makes explicit the contributory role of governmental factors to staff responses to prisoner self-harm. This extends scholarship that identifies clinical, psychosocial and environmental factors (Favril *et al.,* 2020). The greater complexity of prison healthcare increased pressures on staff, which combined with a paucity of staff and resources led to a faster pace. The governmental factors contributing to this pace enabled iatrogenic harms for prisoners and moral injury in healthcare staff. Data also contained well-documented themes, briefly cited here. Prisoner self-harm is perceived by staff as wide-ranging (DeHart *et al.,* 2009, Smith *et al.,* 2019). Repetitive self-harm is particularly challenging for staff to work with (Marzano *et al.,* 2013; Walker *et al.,* 2017; Wilstrand *et al.,* 2007); which is also the case in other healthcare settings (Saunders *et al.,* 2012). Data from this study supported these extant findings. Healthcare staff in other studies, albeit small sample sizes, were less likely to label self-harm as manipulative and had a better understanding of its causes (Kenning *et al.,* 2010; Short *et al.* 2009). This study corroborated this, with participants' keen to deepen their understanding of prisoner self-harm over the course of their career. Participants repeatedly returned to the constrained context – custodial, under funded, under resourced – in which work with prisoner self-harm occurred and the implications of this for them, their practice and the prisoners in their care. This chapter concludes with a contribution to knowledge exploring *disenfranchised trauma* in staff – that is unacknowledged trauma, accrued over time through working with prisoner self-harm. It answers the core research question by highlighting the centrality of governmental factors to staff exposure to and experiences of self-

harm, as well as consideration of disenfranchised trauma, as an enduring and cumulative impact from this work, as posed by research subquestions b) and c).

4a) Prisoner self-harm in an overloaded system

4a.i) Prisoner self-harm in an overloaded system: increasing, severe and different

Prison healthcare staff with long prison work histories noted increases in the frequency and severity of self-harm in recent years. They highlighted that their experiences of prison self-harm were different to working with self-harm in analogous settings: they were more frequent, more severe and on a greater scale. These data were foregrounded by explicit or implicit narratives of a prison system that was under-staffed, over-crowded and in chronic crisis. Firstly, data from this study provides a qualitative contribution that corroborates national statistical data on the increasing *frequency* of self-harm over the last decade, for example 276 incidents per 1,000 prisoners in 2013 had increased to 829 incidents per 1,000 prisoners in 2023 (Ministry of Justice, 2024b). Secondly, data from this study supports extant official data on the increasing *severity:* e.g. self-harm that required hospital admission for treatment was reported as 1,603 attendances in 2013 and 3,349 attendances in 2023 (Ministry of Justice, 2024b). A former nurse with over twenty years' experience explained:

> *' …when I first qualified as a mental health nurse really, that's where you start to see most of this type of behaviour, it was much, much, there was much lower occurrences of it happening. It certainly wasn't as serious. You very rarely saw anybody die from it, but it is becoming more... problematic, I think, as the years have gone on.'*
>
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

Due to the increased volume and severity, working with prisoner self-harm had now become an expected part of the healthcare role, an aspect that staff needed to be able to "manage" to do their job role well. The longer-term implications of this are explored in a later in this chapter in 4.d) disenfranchised trauma and in chapter 6, which conceptualises a staff acclimatisation continuum.

Staff experiences of self-harm in prisons were described as different in frequency, severity and scale to former analogous workplaces, such as medium secure units. Experienced healthcare staff expressed their initial shock when coming to prison healthcare:

> *'… when I first came to this role, I was absolutely astonished by the levels of self-harm that were going on in prisons.'*
> Hilary (B, senior national role, health and justice).

Staff commented on the intensity of working with prisoner self-harm and the unusual, unexpected, ways it manifested.

> *'The self-harm on [wing location] for me was, was the bit was like "Oh my God, I've never seen stuff like this before". I had, but not on the scale, not so many repeats in a day and so many… all at the same time. So, you'd walk from one cell to the next to the next, because they'd be a kinda pattern. That was a grim, grim time. It felt very dark and… it just felt grim down there.'*
> Ashley (A, former RMN and senior healthcare manager)

> *'… being confronted with that degree of self-harm and suicidal behaviour that I hadn't experienced before, even in medium secure* forensic *units […] I did find the very bizarre ways of self-harming very difficult to manage […] You know, even after all those years, there was regularly times when I was like – whoa, I don't know how to respond to this. I've not seen this situation before.'*
> Riley (A, former RGN and senior healthcare manager)

The *severity* of self-harm and its repetition, along with its increased *frequency,* created a chronic healthcare concern and contributed to the difficult-to-manage nature of prison self-harm. Prisoners finding different ways to self-harm led to new clinical and emotional challenges, which, even for seasoned staff, required skill and agility to manage. The *scale* of prison self-harm was the other explicitly mentioned factor:

> *'It just felt quite different. I don't know whether the wards are smaller, the*

prison's massive, the management of it […] the severity of the self-harm or like the frequency of it and the intensity of the thoughts and their experiences are so much greater... and I know that people self-harm when they're manic or very depressed or what you would see in the psychiatric hospitals, but [it] just didn't feel quite as... as rife there.'

Frankie (A, former prison psychologist)

Prison populations range from circa 400 to 2000 people (Howard League, 2023). The design guidance for Psychiatric Intensive Care Units (PICUs) states there should be no more than 14 beds, though units of 10 are common (NAPICU, 2017); medium secure units have between 50 and 100 beds (Völlm and Clarke, 2018). Therefore, there are potentially many more people who could self-harm and need healthcare in prison than in secure settings. Prisoner self-harm is experienced as more frequent, more serious and at greater scale in prisons than analogous settings.

4a.ii) Prisoner self-harm in an overloaded system: under-reported

Data from this study indicated that the combination of under-staffing and high rates of prisoner self-harm led to prisoner self-harm being under-reported. As noted above, prison self-harm rates are at an all-time high. In other analogous settings higher rates of reporting, e.g. patient safety incidents, can indicate that 'organisations have implemented an open and fair culture in which staff learn from things that go wrong' (St. John Smith *et al.,* 2009: 11). However, none of the data in this study suggested an 'open and fair culture' was driving the heightened *reporting* of prison self-harm. Conversely, participants highlighted the increasing seriousness of incidents of prisoner self-harm, citing the difficulties and inadequacies of reporting, suggesting that prisoner self-harm was *under-reported*. As discussed above, prison self-harm was narrated as more severe and more frequent than in analogous settings, meaning that staff had to adjust their standards and expectations to prison realities. Hilary had a long healthcare career prior to commencing a prison role, and explained:

'I started saying, well, they [self-harm incidents] should all be reported. They should all be an incident. They should all be this, they should all be that and it was actually one of the Heads of Healthcare in a Cat A that kind of sat me

down and went […] "… if I was to spend everyday reporting every single incident of self-harm", she said, "I wouldn't get out of my office".'
Hilary (B, senior national role, health and justice)

The current reporting system was built for less acuity and more staff. It cannot support the level of need in prisons and therefore often goes unused. The unfit reporting system may also result in underreporting failed suicide attempts. This former nurse commented:

'They weren't categorised in our risk reporting as near misses at all. Because there'd be too many, wouldn't there? So, what you would class as a near miss in the community or in a hospital setting is different to what you would class as a near miss in a prison. So that was difficult to communicate in NHS meetings […] "well, you should have been reporting all of these!" and it's like, "well... I can't really, cause there's so many"...'
Ashley (A, former RMN and senior healthcare manager)

As prisoner self-harm and suicide attempts are reported less than those in the community, the principle of healthcare equivalence falters, altering the expectation of staff response. Where reporting did happen, it could lack detail, making it harder to then consider what could be changed to prevent reoccurrence:

'You often see an incident report that just says, "patient self-harms". And that's, I guess, useful to know in terms of numbers […] and getting more staff to report it. But it's interesting that they don't really say much more than that […] but it isn't necessarily viewed like a patient safety incident might be, which is, I don't know, patient fell and hurt themselves, which is what you get in the hospital. What we did about it - change the bed or change the environment in some way. I feel like we haven't explored this. And maybe it's a staffing, a resourcing issue, maybe it's because we haven't really looked or don't understand our population sufficiently to know how best? Well maybe […] the judicial system doesn't consider the impacts of an environment like a prison on some of the people that do go in there.'

Alex (B, senior prison health expert and prison doctor)

Above, Alex highlights firstly that staff are making choices about reporting methods, and, secondly, there is also an inability to examine root or environmental causes. The high rates of self-harm in prison can reduce expectation that reoccurrence is preventable and limit imagination around prevention strategies. Poor or no reporting, without expectation of change, encourages the conceptualisation of prisoner self-harm being normal, pedestrian, as much part of prison as keys, gates and plastic cutlery. This is further explored in chapter 6. Prison healthcare staff can find it hard to resist working from these bleak expectations of immutability, particularly when surrounded by proliferating self-harm and suicidal ideation.

4a.iii) Prisoner self-harm in an overloaded system: wider definitions required, including invited violence

Staff shared experiences of a diverse array of self-harm and conceptualised some less acknowledged means of self-harm, e.g. provoking fights. Data included the suggestion of broadening definitions of prison self-harm, here conceptualised to include *invited violence,* which represents a novel contribution to knowledge. Prisoner self-harm is normally associated with cutting and ligaturing (Crighton and Towl, 2002; Hawton *et al.,* 2014). Data in this study supported this, but participants also discussed wide-ranging methods of self-harm including overdoses, head-banging, self-immolation, swallowing objects, maintaining open wounds, internal cutting, blood-letting. For example:

> *'So, we mainly have people like cutting, mainly cutting, swallowing razors, swallowing things. And then, we had like a few of the real like persistent self-injurers who would have like open wounds that they would keep open, like pens, pen lids, head banging, lots and lots of head banging cause I worked with people in the segregation unit a lot. Ligature tying... that kind of thing.'*
>
> Sullivan (A, former frontline VCS healthcare worker)

> *'… overdose or refusal to take medication that sustains their life… and then obviously there was the self-harm through cutting and making lacerations*

[…] I had a gent that would self-harm by um, putting things in his eye […] There was a chap that used to blood let so profoundly, needing regular transfusions […] a prisoner who would regularly self-harm by cutting up his genitals […] very similar to my chap that used to disembowel himself – [he] will maintain open cavities in his abdomen, and has had surgery after surgery… so he's constantly in hospital, will come back and then within an hour or so, he'll do something that requires a readmission to secondary services.'

Riley (A, former RGN and senior healthcare manager)

Staff noted that working in particular roles or locations within a prison meant greater exposure to elevated levels or particular types of self-harm, e.g. when working in the segregation unit. Data demonstrated the persistent and repeated nature of some self-harm – it could recur within the hour and require transfer out to community hospitals to sustain life. The emotional and practical resources required to work with prisoner self-harm went well beyond suturing a wound after being cut. These experiences could remain salient and vivid for staff many years after their occurrence: one such enduring impact, disenfranchised trauma, is explored in chapter 5d.i. Staff reported managing complex situations with limited resources, working at the edges of their expertise, compassion and skills, requiring these to rapidly evolve to meet challenges.

Definitions of prisoner self-harm require expansion to encompass less obvious strategies including *invited violence,* e.g. provoking fights. Additionally, prison tendencies to locating responsibility within an individual minimises the opportunities to understand the range of both the antecedents of self-harm and their manifestation. Prison cultures are macho cultures (Crawley and Crawley, 2008; Tait, 2011). Dominant (mis)conceptions of self-harm are as '"an adolescent thing for (white) girls"' (Chandler and Simopoulou, 2021: 1). Therefore, male prisoners who self-harm can be doubly stigmatised and utilise more socially sanctioned forms of harming themselves such as provoking fights. A systematic literature review of aggression and self-harm suggested that 'aggression and self-harm frequently co-occur' but noted the need for more research on the 'source and nature of cooccurrence' (O'Donnell *et al.,* 2015: 325). Slade and colleagues' quantitative work found an association between prisoner violence

and self-harm and concluded, 'we do not know how, or why, these behaviours develop in tandem, or co-occur' (Slade *et al.,* 2020: 194). Though the authors recommend integrated approaches to managing dual harm, e.g. single case management, they keep these phenomena segregated, stopping short of considering violence directed towards others *as provoking* self-harm. Data from this study support the claim that provoking others to harm you – invited violence – can be self-harm and should be included within self-harm definitions. One former nurse said:

> *'We had somebody who was prolific for punching walls and we had somebody who liked to insert different objects into a wound in their leg. We have people who cut, we have people who had saved up medication. So, you know there was, there was a lot of different types of self-harm going on so. Head banging. I don't know what else... provoking fights with other people so that they could just have a fight. And so, yeah, lots of things, lots of things.'*
> Morgan (A, former RGN)

Data supported wider definitions of self-harm beyond cutting and ligaturing. In this study, participants were not specifically asked about their prison experiences of either dual harm or invited violence as self-harm; this could be explored further in future research.

Current definitions of self-harm can also lack intersectionality and are often predicated on white hegemony. This means that diverse presentations of self-harm – by prisoners with different backgrounds - can be met with punishment and sanctions. This healthcare worker noted the factors of age and ethnicity when considering self-harm:

> *'We need to look into more Black and ethnic minorities young people who, in my anecdotal experience, were less likely to cut, but would often fight with officers, and I perceive that to be like a real form of self-injury. I've perceived that their external need for release was just done in a different way and we kind of didn't look at that as a self-injury we looked at that as aggression and I saw that with like a lot of the younger men I worked with […] I definitely perceived that as a form of self-injury as well, but it would never have gone*

down on their record as such.'

Sullivan (A, former frontline VCS healthcare worker)

Warr (2022: 1092) writes on the need for Black men in prison to '"whiten" their "Blackness"' to pass through their sentence. Findings from this study suggest that this may apply to self-harm too: should Black and other Global Majority prisoners want to have their self-harm identified as such, they are required to self-harm using methods acknowledged by white hegemony. Further interrogation of how age, gender and ethnicity impact conceptions of (prisoner) self-harm could enable greater opportunities for engagement with *all forms* of self-harm, including invited violence and reduce the possibility of it "hiding in plain sight". If prisoner self-harm arises from distress and/or is communication (Adshead, 1998; Miller *et al.,* 2007) and provoking fights were not addressed through purely disciplinary means, it would leave space for response options for both healthcare staff and the institution of prison. They could respond by aiming to address root causes, not just the violent outcomes of those root causes, thereby potentially reducing the occurrence of invited violence. This is deeply challenging in busy prison environments, where violence is increasing and commonplace, e.g. there were 9,204 assaults on prison officers - up 20% in one year (Ministry of Justice, 2024a), and staff lack the time and capacity to reflect upon the intentions underpinning interpersonal violence. In these conditions, institutional understanding of how self-harm both manifests and could be prevented is hindered. Findings in this study suggest that frontline healthcare staff are aware of intersectionality and have broad, inclusive conceptualisations of prisoner self-harm. Yet, in the wider prison system - with a fondness for responsibilisation - self-harm is often too narrowly defined and under-reported, meaning its nature and scale is poorly understood, making effective prevention less likely.

4b) Layers of complexity: ethos, practices and prison itself

Staff working with prisoner self-harm described the layers of complexity that influenced and at times hindered their work. Prisons have a fundamentally different ethos to healthcare settings, so delivering healthcare within them brings a unique set of challenges (MacDonald, 2018; Williams *et al.,* 2018). Prison work involves a tension between care and custody (Liebling, 1992; Tait, 2008). Within this dynamic tension, *how* custodial power is deployed -

legitimately or otherwise – creates significant variability in prison cultures and the survivability of different prisons (Liebling, 2011). For prison healthcare, the 'clash of underpinning philosophies of caring and custody […] is one that cannot be underestimated' (Walsh, 2009: 143). Others note the 'unique culture of the prison environment was not well suited to the values and aspirations of professional nursing practice' (Dale and Woods, 2001: 2). Additionally, working with self-harm is challenging for healthcare staff across settings: at secure forensic sites (Dickinson and Hurley, 2012); in Emergency Departments (Rayner *et al.,* 2019); and, for paramedics (Rees *at al.,* 2016). Responding to self-harm in prison requires working with a medical, therapeutic or human need in an environment that is neither primarily a medical setting, a therapeutic setting, nor necessarily a humane setting (IMB, 2023). Prison factors exacerbate this challenge. In addition to this extant knowledge, the prison healthcare staff in this study cited the profound tension between care and custody as painfully evident when working with people who self-harm. Where custody concerns over-rode (health)care concerns, staff noted the acuity of this tension for them when tending to patients, who were also prisoners. The implications of the ongoing prioritisation of custody over care and security over safeguarding in the sphere of prisoner suicide and self-harm were particularly grave, with participants clearly stating that this exacerbated harm. This finding supports extant scholarship that notes the reconfigurations of the 'texture of penal authority', splitting to two extremes of overbearing or underutilised authority because of cuts to prison staff numbers and the reduction of experienced staff (Crewe and Liebling, 2017: 832). This study also builds on Favril *et al.*'s (2020) contributory factors of prisoner self-harm: clinical, psychosocial and environmental, and argues to explicitly name the addition of governmental factors. Governmental factors are those arising directly from policy, e.g. 22% budget cut to HMPPS between 2010/11 to 2016/17 due to the government austerity programme (Ismail, 2019a). Findings from this study highlighted the layers of complex challenges healthcare staff face as they aim to work with and alleviate prisoner self-harm in a custodial environment.

4b.i) Ethos and practice: custody over care, the unavailability of resources, poor information sharing

Prison settings differ to healthcare settings in their underlying principles, staffing and resources. Prisoner health and healthcare are 'markedly dissimilar to the nature of health and healthcare in wider society' (Jordan, 2011: 1061). Findings from this study affirm that the

ethos underpinning the environment have practical consequences: for responses to self-harm, for the prisoner and the member of healthcare staff. This will be explored in three sections: custody over care, the unavailability of resources and poor information sharing. Firstly, the ethos and manifestation of prioritising custody over care.

> *'… if you worked in an accident and emergency department or in an acute psychiatric care units, you would be exposed to some degree of self-harming behaviour by people, sometimes quite, quite traumatic. But I suppose the difference was you were in a healthcare environment that was set up to both manage the patient and support the staff.'*
> Kerry (B, former prison doctor; senior national role, health and justice)

The rationale of the setting matters. Healthcare settings are ideally able to 'manage the patient and support the staff' (Kerry, as above), based on Hippocratic principles of care; whilst prisons' stated purpose is public protection based on 'holding prisoners securely as they serve the punishment' (Ministry of Justice, 2021: 5). The tension between care and custody for officer staff is well documented (Liebling, 1992; Tait, 2008). A study that examined a small cohort of staff in one prison working with women who self-harmed noted that when staff felt unsure, they felt more confident in a custody role (Short *et al.,* 2009). Healthcare staff in this study reported that security trumped safeguarding, creating new harms and restricting their ability to comply with protocol and/or deliver good care. It enabled one of the vicious circles occurring in prisons with insufficient staff and elevated levels of suicide and self-harm: heightened demands and unmet needs, resulting in poor practice that prioritises security, and consequently less effective prevention of further self-harm and suicides. Participants did share examples of collaborative work with esteemed officer colleagues, but more commonly reported officers whose actions arose from a custodial, rather than care, ethos. This could be enacted to a punitive extent, obstructing healthcare staff in their duties.

> *'I had a code red call so I knew that there was […] blood involved and as I ran with the bag and got to the cell door, the officer said "I wouldn't bother rushing because you know they're gonna do it again." And as I stepped into the cell, I slipped because there was so much blood on the floor. That*

shocked me. And then the lady was sat on the bed. […] the things that I remember about that are slipping on the blood, no response from the prisoner at all in terms of wanting to engage, but it was the prison officer stood in the doorway with his arms folded, leaning against the door frame with his foot up against the door and just going, "you might as well hurry up. There's no point in you being here. She'll do it again." And I found that quite, quite difficult because I thought I don't want to challenge him because she's sat here and she's obviously really upset and I'm trying to clean this arm up.'
Morgan (A, former RGN)

The presence of penal power, custody over care here, minimises and dismisses prisoner distress, creating hostile conditions for healthcare delivery. Healthcare staff can be viewed as guests or visitors, trespassing on normal wings (Piper *et al.,* 2019). Prison healthcare staff were often reliant on officers to unlock and at times, supervise their work: the officers become the gatekeepers of prisoner healthcare. The ethos of security overriding safeguarding whilst not new, is salient to this thesis. It constrained healthcare staff working with those who self-harm.

Resources for working with prisoners who self-harmed were restricted for two main reasons. Firstly, the primacy of the security ethos made some resources impractical. Secondly, austerity reduced prison funding and caused the deterioration of prison healthcare (Ismail, 2023). Findings from this study also indicate that the reduction in resourcing hampered prison healthcare staff in their work with prisoners who self-harmed. A senior role-holder noted the limitations of this work in prison settings,

'[Staff think through] …what you do to help that person, and how do you work with them, where they can... look at different coping mechanisms, but within that secure environment that they haven't got the same access to things that we would have in the community.'
Hilary (B, senior national role, health and justice).

Prison restrictions can be very direct: medication being dispensed at immoveable times, staff unable to refer prisoners to most relevant support service, a lack of social prescribing in prison

(including exercise, arts interventions). Other coping, wellbeing or self-soothing tactics for people who self-harm in the community could be inaccessible in prison: e.g. a cigarette or vape, a walk somewhere beautiful, activities that require quiet and solitude (Deiter *et al.,* 2000). Additionally, a lack of funding restricts the resources with consequences for prison healthcare and staff working with those who are suicidal and self-harming.

> *'We're spending about on average £6000 on healthcare for the average prisoner a year. That's peanuts […] so it's a grossly under invested area given the level of need. I mean you look at how many patients we treat, the average prison contract is […] is about £4- £5 million for a medium average sized prison. But if you look at the number of patients we treat and […] the amount invested per patient, it's just scratching the surface when you look at the need […] so there's a huge health inequality there and if we just increase the investment a bit more, I think we'd get much better outcomes across the system, not just for the individual, but for the whole system.'*
>
> Gurpreet (C, senior national director, health and justice)

Gurpreet highlights prisons place in a wider health and sociological landscape and that the impacts of underinvestment are felt in and outside prison. Alongside these lacking resources, the number of people needing support in prison leads to difficulty accessing stretched services.

> *'… the long-term interventions that those people need […] isn't as, as… readily available within a prison. What is available is exceeding capacity, so it's very difficult to triage people.'*
>
> Riley (A, former RGN and senior healthcare manager)

Following a downturn during the Covid-19 pandemic, prison numbers have surged (HMPPS and Ministry of Justice, 2024). The prison population was 87,973 in February 2024, government statisticians predict it reaching between 94,600 and 114,800 by March 2028 (Ministry of Justice and ONS, 2024). At the time of finalising this thesis (Summer 2024), the

new government was passing prisoner early-release legislation to avoid prisons reaching operational capacity (Hansard, 2024). There were inadequate resources to address the needs of self-harming prisoners at the time of data collection in 2022, with a prison population at year end of 81,806 (HMPPS and Ministry of Justice, 2023). The additional prison population and lack of resources will increase the challenges for staff highlighted by this research and exacerbate prisoner self-harm.

Ineffective, inefficient information sharing created another barrier for staff working with self-harm. Transfer of timely information about a person's health between services across the criminal justice is problematic (Samele *et al.,* 2017). The Prisons and Probation Ombudsman (PPO) have repeatedly raised the failure to share information effectively as a contributory factor to some suicides (PPO, 2022). Data from this study supports these findings. Participants had trouble locating and accessing reliable information on medical histories from GPs, hospitals in the community, courts or police, particularly in busy Category B prisons, which could have enabled better care of those who self-harm.

> *'…where I work the majority of prisons are remands, they're Cat B local remands and so, you have the challenge of a massive throughput of people. Most of who you don't know very well, most of who don't have clear or complete medical records. And some of whom may not be completely transparent with you about mental health history, substance misuse history, et cetera, et cetera.'*
>
> Max (C, former RMH nurse; senior health and justice lead)

The prison gate and segregated IT systems meant prisoners' records were not accessible, inhibiting the standard of care delivered. Overstretched staff were working with the complexity of prisoner self-harm without access to medical records to enable their decisions. Prison healthcare staff faced significant practical barriers in their work with those who were suicidal and self-harming – a setting that prioritised custody over care, the unavailability of resources and poor information sharing – resulting in poorer outcomes for those in their care.

4b.ii) Environmental and governmental contributory factors: prison staff cultures and the "inevitability" of self-harm

Data demonstrated understanding of the range of contributory factors within prisons for self-harm, including a factor conceptualised here as *governmental*. The causes of prisoner self-harm can be understood as 'clinical, psychosocial and environmental' (Favril *et al.,* 2020: 683). Much of the quantitative scholarship has focused on the clinical and psychosocial drivers, e.g. Hawton *et al.,* (2014). The environmental factors are profoundly connected to the political and ideological underpinnings of prison policy and spending. These are extended here and hypothesised as governmental and environmental factors. Governmental - meaning aspects of prison life *directly* affected by government policy, e.g. benchmarking in 2012, including reduction in staff numbers [the ethos] or the forthcoming rearrangement of specialist Health and Justice commissioners to 42 Integrated Care Boards (NHSE, 2022). Environmental – more specifically defined as the fabric of the prison, experienced through the five senses [the practice]. Prison staff cultures are affected by these governmental factors. Liebling and colleagues cite cuts to staff numbers and to experienced staff to demonstrate there have been reconfigurations of penal power which prisoners subsequently evaluate as 'more or less legitimate and these evaluations have a direct impact on their experiences and behaviour' (Crewe and Liebling, 2017: 833). Secondly, to note that the link between these cuts and prison staff cultures that scored poorly in studies about the quality of prison life, because of the treatment of prisoners as 'experienced objects', rather than 'experiencing subjects' with 'emergent personhood' (Liebling, 2019: 202). Liebling concludes prisons can range from the disabling to the enabling, but in the climate of governmental austerity and cuts there is 'a cost threshold [that] can be crossed below which prisons become simply ungovernable and therefore disabling to all' (Liebling, 2019: 203). Additionally, participants in this study understood *other* contributory factors to self-harm, acknowledging "imported vulnerability" - pre-existing factors within prisoners coming into prison (Liebling, 1999; 2011; 2017; Ludlow *et al.,* 2015). Yet, data showed staff viewed prisoner self-harm as, in part, caused and exacerbated by environmental and governmental factors, demonstrating understanding that the causes and alleviation of self-harm could not simply be responsibilised into one individual. Participants repeatedly cited the 'extremely stressful' (Riley) prison environments as a primary cause of self-harm. This supports extant scholarship (Bennett and Dyson, 2014; Ludlow *et al.,* 2015; Marzano, 2007; Pannell *et al.,* 2003). It corroborates research that found prison

healthcare staff identify the prison environment as a key driver of self-harm from a small study, with five healthcare participants (Kenning *et al.,* 2010; Short *et al.,* 2009). Staff can view self-harm as a 'coping mechanism to deal with the harsh prison environment' (Ramluggun, 2013: 27). Findings from this study partially support this: rather than a coping strategy, staff describe prisoner self-harm as a *response* to the environment and as a proportionate response to the pains of imprisonment.

Data suggested these diminished prison environments stifled therapeutic attempts to work with self-harm and contributed to its prevalence, making self-harm seem an inescapable outcome. Participants reflected that self-harm was partially a response to the stressful prison environment with its regimes, restrictions and surveillance:

> *'… once he goes into the community - he doesn't self-harm at all. And you see that a lot, you see people that never self-harmed on the outside. Or do it on the inside and then on release don't […] because we have to remember that a lot of these people don't have an organic mental illness and what they're doing to themselves is what we'd actually expect a human to do once we put them in an extremely stressful and limited environment with no control. So, it's not that unusual to see this, there's research about […] like the stress impacts of rats or mice when you put them in certain environments, and it's very similar to what we see, what happens to people when they're incarcerated.'*
>
> Riley (A, former RGN and senior healthcare manager)

> *'We've got 60 odd on a wing, five of which are self-harmers. "We don't want any more than five self-harmers, we want the self-harming numbers to be reduced". Sorry, but you're not gonna have that, not working in the prison environment, in my opinion for what it's worth. You got two, sometimes three people to a cell, the noise that's going on. Fights breaking out. […] A lot of their self-harmers were vulnerable […]. It's, it's stressful for them. Um and it was a case of - them watching us, watching them. You're living in a, they're living in a goldfish bowl.'*

Charlie (A, former RMH)

The contributory, brutalising nature of the prison environment is highlighted above. Self-harm is framed as almost inevitable or logical, a normal response to a stressful setting where autonomy is severely restricted. It supports theorisations of prison as permeated by 'the spirit of death', the civil, social and, sometimes, corporeal death encountered by prisoners (Scott, 2018: 164) or Foucauldian conceptions of prison as an immutable 'death machine' (Foucault, 2002: 419). However, it is possible to name the governmental factors, e.g. restrictions to funding and policy decisions, that shape prison environments, staff cultures and how these contribute to self-harm and yet, still imagine alternatives.

> *'… the self-harm is induced by the prison environment isn't it? […] I could honestly, truly believe that in a few years' time, somebody somewhere will be apologising for the fact that we have incarcerated so many people over so many years in this absolutely appalling model of care.'*
> Sheridan (B, range of senior national health and justice roles, past and present)

The quality of the prison setting, the staffing, whether prison is the most appropriate setting for those who are acutely ill, the care provided, matters. The ingredients that make up the current 'model of care' can be changed, as the ontological approach here understands the world as dynamic and interconnected, so shift and change can be consequential, from small acts to new legislation. For example, those who self-harm could be listened to and better understood, government policies to reduce self-harm could be evidence, not ideology, based. Staff identified environmental factors, in many cases shaped by governmental factors, as contributory to prisoner self-harm.

Prioritising custody over care, the lack of resources and poor information sharing made working with prisoner self-harm increasingly difficult in environments and staff cultures that were diminished and made more complex due to governmental factors. These factors have created prison cultures that are disabling environments, diminishing emergent possibilities and personhoods, shutting down expressions of alternatives to self-harm, reinforcing a sense of inevitability around its occurrence. However, the ingredients of the model of care are not

immutable. Prisoner self-harm is not inevitable. Yet it is profoundly understandable that those in draining prison healthcare roles do not hold this view. This then had the enduring impact of impairing staff capacity to imagine, to hope that things could be different and thereby positively influence their practice.

4c) Experiencing self-harm as one demand amongst many: pressure, paucity and pace

Within this complex and contributory prison setting, self-harm can become viewed as another demand to be managed. This then further obscures the person and their unmet needs, creating additional harm. Demands are 'physical, social or organizational aspects of the job that require sustained mental or physical effort', these efforts have consequences for the individual making them and 'can deplete energy and impair health' (Kinman *et al.*, 2017: 457). Imbalance between resources and demands can lead to long-term stress (Finney *et al.,* 2013) and burnout (Schaufeli and Peeters, 2000) in prison officers. Hospital healthcare staff also experience demand outstripping resources, creating burnout and further staff shortages (Deakin, 2022; Montgomery, 2019). Understaffing in prisons can lead to feelings of powerlessness and vulnerability in officer cohorts (Shefer and Liebling, 2008), feelings that may then be amplified in working with prisoner self-harm. Walker and colleagues note 'the feasibility of repeatedly dealing with this issue within an environment where there are poor facilities, overcrowding and a lack of resources' e.g. an environment created by the governmental factors (Walker *et al.,* 2016: 182). Findings from this study support Walker *et al.'s* contention, emphasising the contextual importance for the healthcare delivered to those who self-harm. This thesis develops existing scholarship by considering the implications - for both prisoners and staff members – of working with increased demands creating *pressures*, a *paucity* of resources (including staff) and which then requires a faster *pace*. This thesis also extends the concept of iatrogenic harm, that is 'harm occurring as a result of healthcare practices or procedures' (Griffiths et al., 2022: 36), to explicitly identify *systemic* factors as contributory to iatrogenic harms, e.g. low contractual staff minimums, and not just harm arising from individual actions. Squeezed staff may view prisoner self-harm as inevitable, as noted in 4b.ii, and mean a portion of self-harm is (un)treated as inconsequential, resulting in

iatrogenic outcomes and prisoner neglect, irrespective of the intentions of the healthcare staff.

4c.i) Greater complexity creates pressure

Healthcare staff were expected to manage ever-increasing complexity in the prison population, including in work with those who self-harm. This thesis situates prisons *as part of society,* as opposed to being segregated total institutions. As such, they bear the consequences of failings in other parts of society, e.g. the lack of affordable housing and/or difficulty accessing GP services. Prisoners have long been acknowledged to carry a 'disproportionate burden of physical and psychiatric disease' (Fazel and Baillargeon, 2011: 962). The social determinants of health matter: between 2010 and 2020 life expectancy in England declined and people spent more time in poor health due to social and economic inequalities (Marmot *et al.*, 2020). The barriers to good health *outside* of prisons have implications for those living and working *inside* prisons. Those incarcerated are entering prisons with increased complexity, co-morbidity and dual diagnoses. The management cohort of participants emphasised this; some saw the positive aspect of skills development, but most data spoke of the significant challenges it raised.

> *'I've seen that level of complexity but also sophistication in care, just develop year on year on year.'*
> Sasha (C, senior health and justice manager)

> *'… that level of need and comorbidity and complexity is reflected everywhere. I've never known the people coming into prison be as complex as they are at the moment, so I think that you have an unskilled workforce, and the workforce where there's no possibility of them getting the skills that they need in order to support these people well. Because they can't even get people on their mandatory training within the prisons, let alone send them on detailed training programmes around how to support vulnerabilities, so there's no chance of that improving...'*
> Max (C, former RMH nurse; senior health and justice lead)

Max had worked in prison healthcare since 2016. Data contained examples of frustration at the apparent impossibility of improvement with a workforce unable to access the training they needed for this heightened complexity, due to staffing pressures. This then created a sense of futility. The rise in comorbidities and complexities created pressures on staff in a system that lacked the capacity to equip them to better respond to such shifts in their patient cohort.

4c.ii) Paucity of healthcare staff = paucity of care

A paucity *of staff* created two unintended consequences: staff could not work with *everyone* in need and sometimes, staff could not work with *anyone*, creating iatrogenic harms and neglect. Iatrogenesis is unintentional harm to patients arising from healthcare, medical neglect is more specifically defined as 'failure to use reasonable care' due to 'departures from accepted standards of care' (Klaas *et al*., 2014: 1279). This means that 'while all harm that results from negligence is iatrogenic, not all iatrogenic injury is negligent' (Sampath, 2022: 736). The paucity of healthcare staff could facilitate both iatrogenic harms and negligence. The Royal College of Nursing found prisoners' essential healthcare needs were not being met: 64% of their prison nurse sample reported that care was compromised on their last shift and 45% attributed that to staff shortages (House of Commons, 2018). Scholars agree. There is a 'relationship between the material resources of prisons and their moral quality', with risks to prison order and safety from 'reducing staffing levels below a safe minimum' (Liebling, 2019: 193, 203). Piper *et al.,* (2019: 580) directly link 'austerity-level resource allocation and working conditions' with staff's inability to 'provide the quality of healthcare delivery that prisoners' multiple needs require'. Ismail suggests that staff reductions 'likely… influenced the unprecedented 57% increase in both self-harm and assaults among prisoners between March 2010 and March 2019' (Ismail, 2020a: 1369). The low number of contracted healthcare staff in prisons was then further exacerbated by rates of illness, retention issues and over-reliance on agency staff. Data in this study builds on this previous work to demonstrate some of the iatrogenic consequences of these lower staffing levels on prisoners who self-harm.

Data directly linked staffing pressures to participants' (in)ability to respond to prisoner self-harm as they would wish to, creating a *paucity of care* for prisoners. Healthcare staff were not contracted to be available in every prison 24 hours a day; where they were, staffing levels

could be minimal, e.g. one nurse on site overnight for the whole prison. Not having enough staff to meet the need was reported across staff cohorts, not solely by nurses and GPs. This participant explained:

> *'… in terms of the... sheer amount of people who were self-harming, and our ability to actually sit and think about that specifically with everyone - it just wasn't possible for the amount of staff that we had.'*
> Sammy (A, former prison psychologist)

There were not sufficient staff - psychologists in this case - to think through working with each person that self-harmed in that prison. Staff rationalised this stark disparity between resources and the "demand" of self-harm to enable functionality in difficult circumstances. This finding supports Warr's (2020: 137) work on prison psychologists which highlights Trotter and Ward's (2013) concept of 'ethical blindness', whereby practitioners become blind to the consequences of their actions – including the harms they may cause those in their care – due to the institutional or job role lens through which they perceive. Consequently, staff in this study categorised and prioritised the self-harm, only able to work with those understood to have the greatest need. This categorisation is reminiscent of scholarship that demonstrated officer staff often distinguish self-harm as genuine or non-genuine and then respond according to that belief (Liebling, 1992; Pannell *et al.,* 2003; Short *et al.,* 2009). Whilst understandable in the context, employed consistently as a strategy over time, this categorisation leads to iatrogenic outcomes and prisoner neglect by staff somewhat "blinded" to these outcomes. Alex summarised the issue:

> *'You need the resources, you need the systems to work in place so that you can assess the risk and manage the risk in a more appropriate way. But if you're starting from a defensive position because you're under-resourced, you're in a kinda catch 22, aren't you?'*
> Alex (B, senior prison health expert and prison doctor)

Data conveyed the circular nature of the problem, the sense of scarcity and the lack of options for improvement without creating issues elsewhere. Categorisation impinges on the delivery

of healthcare and creates a cohort of prisoners who self-harm that are neglected without a healthcare response to their self-harm and the root causes of it. Ongoing self-harm suggests ongoing unmet needs, or perhaps needs unseen by "blinded" staff, indicative of a paucity of care.

Low contractual minimums, compounded by staff sickness, set prison healthcare up to fail and compromised care for those who are self-harming. This supports Liebling's findings on the quality of prison life, as she summarises in one introduction. 'Cheap prisons are not a good policy option' (Liebling, 2019: 193). The finding here corroborates Ismail's assertion that with austerity and benchmarking funding cuts, prison healthcare providers walk a 'tightrope, between quality and cost' (Ismail, 2023: 92) and that staff numbers had been reduced to levels that were unsafe (Ismail, 2020a). Findings from this study agree and extend Ismail's work, providing examples of the consequences of this, as prison healthcare falls off this 'tightrope', failing prisoners and staff. For example, low levels of staff resulted in a healthcare support worker (equivalent to a healthcare assistant role) being the only healthcare member of staff in the prison overnight.

> *'I did a full night shift in Prison A with no nurse on site. The nurse didn't come in. So, the day nurse stayed till 10:00 or 11:00 PM. And the doctor that was doing reception stayed on call till 12 or half 12, but pretty much from 11 onwards, I was on my own till 7:00 AM the next morning and that night somebody did cut themselves. Um but... she told the officer that attended that she didn't want to be seen by me and just asked for a dressing. So, I just sent a dressing down so, I never actually saw her cuts […] it was a proper cock up really […] there should have been somebody registered on site. That's part of their contract to make sure that they provide registered healthcare at all times, but there was me and the officers that who were in charge […] and everybody that was working that night was very much aware that if a call came into healthcare, that an ambulance was to be rang immediately, regardless of the incident because it obviously could be stood down […] then at least we would have a registered person on site.'*
> Jude (A, healthcare support worker)

Neither the participant nor their employer thought this level of staffing was acceptable. The person self-harming is unattended, arguably in response to their wishes, which ensured the staff member's availability should something else "more serious" arise. If the incident had involved arterial cutting, the outcome may have been very different. Jude's candid description was an outlier in the data, yet it was clear that prisons are attempting to function precariously, with demand outstripping staff to the extent that prisons can be one person's sick leave away from disaster and/or death. Overnight night staff minimums have been correlated with damage and fatality in other cases, for example, the death of Alex Braund at HMP Nottingham, with one nurse and one healthcare assistant on duty in a prison of 800 men (Inquest, 2022). Further research would enable a clearer picture of both contractual and actual prison healthcare staffing levels, as well as exploring the potentially fatal harms of low contractual levels and the consequent paucity of care.

4c.iii) Faster pace contributes to further harms and moral injury

This combination of rising need – both in number and acuity – and a paucity of healthcare staff, created a faster pace, further coercing *healthcare* into *prison* rhythms. Criminologists have considered time as a commodity that is 'linear and goal-oriented, measurable, accountable and definable in terms of monetary value' (Nellis, 2002: 64). Exploring the probation service within courts, Robinson noted the 'recalibration of a new temporal order' to achieve the 'court's desired pace' due to coercive isomorphism, that is the process of one organisation being pressurised by another on which it is dependent (Robinson, 2022: 214). Extending Robinson's contention, prison healthcare staff experience the coercive isomorphism of the prison system, reducing their temporal capital and expecting an ever-quickening pace. Participants spoke about the pressures to deliver prison healthcare at speed and strategies to do so. This former nurse talked about the medication round:

> *'… you're literally firing them through, one patient every two minutes, and it's so stressful […] But you couldn't get the job done without cutting some corners. And that was always at the back of your mind. That was a, a big stress - cutting corners just to try and try and get job done. [...] you're thinking to yourself – bloody hellfire! When am I gonna get five minutes here to try and take a breath*

and evaluate what I'm doing?'

Charlie (A, former RGN)

Charlie's data highlights the lack of time for pause, for thinking or evaluating actions taken. Participants also then linked this fast pace to escalating self-harm, as prisoners' initial needs go unmet and create a further set of needs due to the neglect of the initial presenting need(s).

'… the fast-paced environment where there's so many people who are wanting so many different things and under resourced in terms of prison staff not being able to support everyone to the extent that they need. Self-harm sometimes being a way of communicating, kind of – "I need help and you're not listening", in that kind of fast-paced environment.'

Sammy (A, former prison psychologist)

'Well, how do I cope with this? These people that are self-harming, when I know that I've got a few minutes to deal with this person who just cut their wrists or their neck or something. But I know I've got to go on and deal with something else. But an officer on another landing is calling me about that, I need to go and see or I've got to get down to Reception because then the people are coming in and the Reception officer is yelling at me because they want to get home. All that sort of chaos that we talked about at the beginning – that means I could say, well, I've only got a few minutes to be with this person, to make a decision about opening an ACCT or dressing their wounds or a bit of both or letting the GP know or whatever it might be… You could only do so much in that finite period of time. So, there's often no kind of end to that.'

Alex (B, senior prison health expert and prison doctor)

Data conveyed the constant demands on healthcare staff. Alex poignantly contrasted the limited nature of time on a prison shift and the infinity of the needs encountered. This study demonstrates that staff made decisions under significant pressures. Staff worked in response to managerial time, rather than process time (Nellis, 2002). Process time means taking the length of time the task requires shaped by 'the needs and reality of the care receiver' (Davies,

1994: 281). In a forensic psychiatric setting study, staff struggled to 'find the time' to manage their emotional response to their patients' self-harm (O'Hara *et al.,* 2021: 5). Findings from this study suggest that managerial time means the care giver is also unable to attend to their own needs and reality.

> *'… the challenges are about being able to get done what you need to get done, because time is always a valuable commodity, isn't it? There's never enough time to do anything […]and I think sometimes there's so much to do immediately post an incident, that actually sometimes, it prevents people from being able to process properly what's actually happened.'*
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

Bureaucracy and protocols can prevent staff processing, reflecting and learning from incidents: this is further explored in section 4d. This mirrored judicial contexts, where time pressures arising from high workloads and 'efficiency targets' were associated with routinised approaches and 'a resultant loss of judicial discretion' (Carr and Maguire, 2022: 234). Staff did not always have time to think before acting. Healthcare shaped by managerial time, at this unthinking pace, could lead to substandard practices – either by omission or speed. This is not unique to prison healthcare (Van Bogaert *et al.,* 2012; Wang, 2019). Though iatrogenic harms from managerial time may be less constrained in a setting the is primarily custodial and not based in (health)care. Healthcare staff were keen to reduce self-harm yet constrained by the low practitioner numbers and high prisoner needs: the faster pace.

Faster pace created an unacceptable divergence between the service prison healthcare staff *wished to* provide and the service they were *able to* provide, leading to staff stress and potential moral injury. This finding represents a novel contribution to knowledge. A foundational definition of moral injury, a term originating from medical sociology, states it is 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations' (Litz *et al*., 2009: 697). Moral injury was a significant predictor of higher overall PTSD symptoms in law enforcement staff (Papazoglou *et al.,* 2020) and has been associated with PTSD, depression and suicidality (Williamson *et al.,* 2021). Moral injury can 'threaten one's deeply held beliefs and trust', causing feelings of

'shame and guilt, and alterations in cognitions and beliefs… as well as maladaptive coping responses' (Williamson *et al.,* 2021: 453). Moral injury was a finding in this prison healthcare staff study and suggests that some staff were not ethically blinded by their 'limiting professional lens' (Warr, 2020: 134) to the consequences and harms that may arise from their actions. Staff's identity as *healthcare* staff, and not prison staff, was given primacy: it was healthcare boundaries or standards that were being transgressed. These moral injuries as expressed in the data, occurred in a context of prisons that 'vary significantly in their moral and relational climates', which Liebling (2011: 534) notes are determined by prisoners' treatment *by* staff. The finding here extends this work to show that institutional and managerial treatment *of* staff, as influenced by governmental factors, could create moral injury influencing the moral climate of a prison.

Staff were upset and frustrated at the limitations they worked with, which could contribute to moral injury. Fin explained:

> *'It's tough. It's challenging. It's... sometimes quite frustrating. Sometimes it feels like you, I are almost trying to deliver healthcare with one hand tied behind my back […] I'm definitely up for a challenge, but I think it sometimes it, it almost... inhibits... your ability really to deliver really good healthcare […] you're constrained by the bricks, the environment, the locks, the keys, the systems, the processes, everything really. […] I don't think we do enough to say just how distressing it can [be].'*
>
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

Data contained examples of staff experiencing the wide-range of constraints in prison healthcare work as distressing because of the impact on their ability to deliver 'really good healthcare' to those who were suicidal and self-harming (Fin, as above). Other data contained staff grappling with the moral injury created by the presence and prevalence of suicide and self-harm in prisons, the feelings of guilt and concerns about competency, when unacceptable things happen.

> *'But there is a sense, any healthcare professional feels when confronted with*

that, […] a sense that these are vulnerable people in our care and the ultimate care failure, is that they have been motivated to either try to harm themselves […] these are people in our care, vulnerable people in our care.'
Kerry, (B, former prison doctor; senior national role, health and justice)

Kerry here several times highlights the identity of prisoners as those who are to be cared for by healthcare staff and the difficulties experienced by staff when this is not the primary aim. Staff also relayed examples of work with suicidal prisoners with decisions made based on limited resources, which transgressed their boundary of acceptability. Hayden reflected on their experience with a prisoner that could not be accommodated on an at capacity healthcare wing:

'… sometimes the decisions you make are hard, hard to live with and stuff like that […] You have to be brutally honest with yourself and try and make sure things like that don't happen again. But then again, there's only a finite amount of resources and a finite number of inpatient beds, and not everyone who needs one gets them sort of thing so...'
Hayden (A, former prison nurse/healthcare officer)

Data here highlighted the enduring impacts of living with decisions made because of limited resources that were unacceptable to the practitioner, who decades later is wrestling with the constraints and their ability to influence the outcome within such a setting. Moral injury experienced by staff after completed suicides, is explored as part of chapter 5b. Healthcare staff in prisons working with self-harming and suicidal prisoners could find constraining, low resource prison environments and the pace of work resulted in moral injury. Without appropriate support, this had an enduring impact on staff.

The pressures, paucity and pace of contemporary prison healthcare can mean self-harm becomes a demand to be managed like any other and not an unmet need that should be "seen" and is complex, requiring process time, care and attention. This contributed to neglectful and iatrogenic consequences for prisoners who self-harmed. Healthcare staff so constrained by the prison, low staffing levels and the fast pace, experienced distress and, in

some cases, moral injury. Moral injury, if unattended, could remain with staff over several years causing ongoing rumination, feelings of guilt, questions about competency and have implications for staff retention and for the prisoners in their care.

4d) Unacknowledged trauma over time becomes disenfranchised trauma

In this overloaded system, with its harmful pressures, paucity and pace, was the occurrence in the data of disenfranchised trauma, a novel contribution of this thesis. Both moral injury and disenfranchised trauma are often unattended, with impacts that accumulate and embed over time. Disenfranchised trauma is trauma arising from cumulative experiences and/or trauma that cannot be openly acknowledged (Thompson and Doka, 2017). Correctional staff can experience trauma through their work, with some staff exhibiting PTSD symptoms following workplace experiences (James and Todak, 2018; Spinaris *et al.,* 2012). Prison healthcare staff count prisoner self-harm as a potentially traumatic event, representing 'a significant occupational hazard for prison mental health nurses and correctional officers' (Bell *et al.,* 2019: 5). However, one of the challenges of identifying trauma is that burying it is a normal reaction (Herman, 1992). Recovery from trauma therefore requires feeling safe, remembering what happened and then reconnecting with life (Herman, 1992). These three phases of recovery are ill-suited to prisons where prisoner perceptions of their own safety are declining (HMIP: 2023) and staff use emotional labour to suppress feelings and to sustain themselves (Crawley, 2004a; Walsh 2009). This also makes it more difficult to glean a comprehensive picture of the distressing and, at times, traumatising nature of prisoner self-harm, for both prisoners and staff. Unacknowledged traumatic experiences can then lead to occurrences of *disenfranchised* trauma.

Disenfranchised trauma has been developed from Doka's concept of disenfranchised grief, which is loss 'that is not or cannot be openly acknowledged, socially sanctioned or publicly mourned' (Doka, 1989: 4). In extending disenfranchised grief into disenfranchised trauma, Thompson and Doka (2017) highlight that trauma has primarily been seen as an outcome of a single incident. This overlooks potential trauma due to cumulative experiences, where trauma is incurred by 'continuing, prolonged and repeated experiences' (Thompson, 2017:

91). Unlike previous papers, this research provides tangible examples of disenfranchised trauma, in this case, the continuing, prolonged and repeated experiences of prisoner self-harm. This study also recognises the double denial disenfranchised trauma involves. One denial being the impulse to bury trauma, the other being the lack of recognition of trauma caused by cumulative exposure instead of a singular catalysing event. This void of acknowledgement goes beyond the surface acting of emotional labour used to retain professionalism in gruelling prison healthcare roles (Walsh, 2009). Disenfranchised trauma may contribute to staff habitually disconnecting or disassociating from distressing feelings and/or mean they are subject to institutional silence about their traumatic experience(s) of prisoner self-harm. This section considers how disenfranchised trauma is created in prison healthcare staff: through denial and through cumulative exposure, which is exacerbated by the acuity of need without sufficient resources.

4d.i) Unacknowledged trauma: denial

Disenfranchised trauma can be created by working with prisoners who self-harm over time. Working with people who self-harm can be complex and emotionally draining (McGough *et el.,* 2021), and at times, traumatic (James and Todak, 2018). When working in prison healthcare, this went unacknowledged - institutionally and individually. Institutionally, staff support staff may have increased (Marzano and Adler, 2007). But prisons still normalise and minimise the distressing nature of working with self-harm, putting the onus on the individual staff member to process this work and access interventions: another example of responsibilisation. The normalisation of self-harm is further explored in chapter 6. The institutional minimising silences healthcare worker experiences, which staff themselves may contribute to, restricting prison epistemology. Individually, prisons are documented as being 'masculine' workplace cultures, full of bravado (Cassidy and Bruce, 2019), where staff may be seen as inept if they admit to particular emotions (Ramluggan, 2013). Staff experiences could be marginalised by the pace and acuity of their work, meaning staff became inured through chronic exposure and had ceased noticing impacts on themselves or their practice.

> *'… we see that staff get inured to trauma because it's so constant, it's so expected. And they get inured to understaffing so that they stop reporting it.'*
> Drew (C, former prison doctor; national manager, prison health

As well as a lack of noticing, prison staff working with self-harm could deny the negative impacts on them (Smith *et al.,* 2019). This study agrees. Data reflected the expectation that staff "should" be able to "cope", irrespective of institutional context, e.g. unprecedented rates of self-harm, low staff numbers, providing examples of staff "coping" silently and alone.

> *'Speaker 2: And then I mean anything else that you've observed in colleagues or staff about how they, how you do manage that impact on themselves? Speaker 1: […] I don't know because I think a lot of it's unspoken.*
> Alex (B, senior prison health expert and prison doctor)

> *'Can I say for definite it had an effect on me? Of course it did. It would affect anybody. […] I should have asked for a sit down with the boss, but you just lose yourself when you work and get on with it […] You just walk, you just walk away. And you try and forget.'*
> Charlie (A, former RMH)

Findings from this study extend that of Smith *et al.* (2019): participants interviewed were mostly one step removed by time or by role from frontline work, enabling the admission of how their historic work has affected them. Participants could now name working with self-harm as traumatising, their own denial and the institutional lack of acknowledgement of that. This denial to manage emotions is not new in prison or nursing settings (Crawley, 2004a and Menzies Lyth, 1988, respectively). It enabled staff to continue with their work in prisons. Unsurprisingly, it was a psychotherapist participant who explicitly highlighted the denial many staff employed to deal with trauma and offered an alternative.

> *'… that it won't affect you to take babies away from their mothers, that it won't affect you to clean up the blood or […] have it drip on you in the therapy session. Of course it will! We can talk about it. It could bring us together.'*
> Bobby (A, former prison psychotherapist)

The role of talking, connection, being listened to, being part of a team and not just an individual processing these things, contrasted with other participants' accounts of how they dealt with the difficulty of this work whilst in the workplace. Without sufficient alternatives, denial sustained staff but embedded unacknowledged trauma.

4d.ii) Disenfranchised trauma: acuity, chronicity, lack of resources

There is a lacuna in scholarship about the impacts of working with prisoner self-harm over time. Data from this study suggests that staff can experience trauma that is not recognised as such because it arises from a series of events over time and not from a singular catalysing incident. Studies from other genres of healthcare demonstrate the importance of temporality, e.g. depression and post-traumatic stress disorder are over-represented in military healthcare staff with *prolonged* exposure to 'war stress' (Palgi *et al.,* 2009: 262). Senior management participants in this study identified that the ongoing nature of self-harm in some prisons meant staff were unable to either acknowledge, process or reflect on their work.

> *'And I think what you often, if you go to places like Prison B [women's estate], where it's endemic, self-harm is endemic, you know, you, you don't often get the chance to process what's going on.'*
> Gurpreet (national manager, prison health)

Another senior practitioner explored this is more detail, naming the trauma staff can experience through this work and how it can accumulate over time.

> *'…frontline staff […] having been confronted with sometimes appalling injuries that they're then traumatised themselves as providers of care. And I worry about that, the ability we have to support frontline staff who are exposed to that [self-harm] sometimes on a daily basis, as well as obviously the people who are suffering those injuries. And making sure that that is recognised and appropriate support's put in, can be very challenging […] I'm sure nobody intends to be unsupportive, but just the lived experience of healthcare*

workers can mean they are literally bouncing from one crisis to the next, and maybe not getting the time they need to recover from that experience and process it themselves.'

Kerry (B, former prison doctor; senior national role, health and justice)

Time to spend with prisoners is severely limited. Time to understand what you have experienced personally and professionally following prisoner self-harm is severely limited, as is time to reflect *with others* on how this may have impacted you before moving on to the next 'crisis'. The practitioner risks accumulating these difficult and, at times, traumatic experiences which can then overflow into their attitudes and practice, because they have not been allowed time, resources or support to 'recover… and process it'. Marzano and Adler (2007) summarise the categories of support for prison staff working with self-harm to reduce stress. Primary means involve tackling root causes, the content and context of the work; secondary means often involve training to limit the impact of the work on staff; and tertiary means, the most commonplace, which aid staff to recover and continue to work. The authors in 2007, a time of considerably lower rates of self-harm in prison, recognised that primary, secondary and even tertiary interventions may be 'impractical' after every incident of self-harm (Marzano and Adler, 2007: 277). Data from this study suggests staff are often unable to access even tertiary means of support - e.g. local care teams, debriefing - neglecting secondary means - e.g. regular clinical supervision, and leaving staff to manage any consequences alone. This time pressure isolates staff, and exacerbates and embeds the disenfranchisement of trauma.

Working with an acute level of self-harm, over time without commensurate resources meant staff were stymied in both acknowledging and then processing traumatic incidents of prisoner self-harm. This contributed to disenfranchised trauma. Data in this study clearly linked the acuity of need with coping via denial.

'… and you just get on with it, when you deal with something barbaric, you just crack on with the next case and that's a bit worrying in some ways!'

Drew (C, former prison doctor; national manager, prison health)

Drew continued, comparing the work to a field hospital in a war zone to highlight the acuity of need and the lack of resources.

> *'Some of our nurses have worked in the armed forces before and one in particular was talking about working at Camp Bastion, so dealing with, in a field hospital essentially, with some pretty horrendous injuries. And we were talking about that and prison healthcare and some of the traumas that you see along similar lines sometimes, and she was saying that there are similarities…'*
>
> Drew (C, former prison doctor; national manager, prison health)

Participants repeatedly discussed the necessity of denial as a coping strategy in an environment as demanding yet under-resourced as this. Others went further highlighting the way staff detached and disengaged to maintain functionality at work.

> *'… that's the process that people need to go through, the healthcare staff need to go through that, to wheel themselves back emotionally from what they're seeing. And it's a coping strategy. I'm not saying it's a good coping strategy, but it's something that I've certainly seen people deploy and if you see other staff members doing that, then it normalises it and makes it acceptable to do so. But again, as I say, if we're working in restricted environments, we've poor resourcing and few options…'*
>
> Alex (B, senior prison health expert and prison doctor)

This normalising can create a vicious circle: being detached is permissive for others to do likewise, until there is no expectation that these encounters would being upsetting, let alone traumatising. This creates the potential for further unacknowledged, disenfranchised trauma, as staff may view other staff's distress as illegitimate in a workforce of peers who seem able to "cope". Participants like Alex were aware of the inadequacy of this as a coping strategy, but viewed this as a pragmatic response to working with self-harm in an under-resourced prison setting.

There were pockets of hope in the data: participants who found ways to acknowledge and aid the processing of these traumatic incidents of self-harm with colleagues. Processes are interruptible and outcomes mutable (pockets of hope are further explored in Chapter 8.) Riley recalled their colleague:

> *'And she saw very much trauma, she was an excellent clinical matron. Perfect for prison […] she hadn't realised how deeply affected by that she was because, cos there's always more work to do. There's always someone else to go see. There's always more meds to issue, and the next shift to do. I just remember her finding it really difficult to speak about. I could see the struggle on her trying to comprehend and process and trying to tell me about it. And then her realisation, like, that she didn't realise that it was still living with her.'*
> Riley (A, former RGN and senior healthcare manager)

Riley is clear that the pace of work prevented their matron colleague noticing the impact of traumatic incidents on herself. In a safe space, through conversation with a trusted colleague, this matron was able to begin to observe that she was still 'living' with the traumatic things she had experienced. In terms of Herman's phases of trauma recovery: the matron felt safe (phase one) and so was able to remember what happened (phase two). It took time, space and another person for this trauma to move out from being disenfranchised trauma, into acknowledged trauma from where recovery journeys at least become possible. Staff are adept at finding ways of functioning, of doing their jobs despite the myriad difficulties created by poor resources coupled with high needs. This is further explored in chapter 6. Disconnection and allowing traumatic experiences to go unnoticed created disenfranchised trauma but enabled staff to retain a level of functionality.

Conclusion

The first section of this chapter demonstrated prison healthcare staff experiences of prisoner self-harm have increased in number and severity, even though data from this study also suggests it is under-reported. This qualitative finding corroborates existing statistical data from the Ministry of Justice. Novel findings were that staff considered prisoner self-harm as

different in frequency, severity and scale to that in analogous settings; and the proposition of wider definitions of self-harm that include invited violence. Intersectional, broad, inclusive conceptualisations of self-harm will aid understanding of the scale and nature of it, enabling more effective prevention. Section two argued that layers of complexity in both ethos and practice complicated and at times hindered prison healthcare staff's work. The reduction in resourcing hampered work with prisoners who self-harmed. These deteriorating prison environments not only stifled therapeutic attempts to work with self-harm, but contributed to its prevalence, making self-harm seem an inescapable outcome: governmental factors are an under-acknowledged part of this. The complex and contributory prison setting can obscure the prisoner and their unmet needs. This study found low contractual minimums created a paucity of healthcare staff and therefore a paucity of care. Squeezed staff could view self-harm as another demand to be managed, creating additional iatrogenic harms and prisoner neglect. This contributed to ongoing prisoner self-harm, symptomatic of unmet prisoner needs. Nascent novel findings suggest staff's constrained ability to deliver healthcare to self-harming prisoners created distress and moral injury in staff. The final section of this chapter considered the occurrence of disenfranchised trauma in prison healthcare staff who work with self-harm. Staff denial, a lack of recognition of the potential for cumulative trauma and the high workloads that isolate staff and stymie the processing traumatic events, all contributed to the occurrence of disenfranchised trauma. The findings of governmental factors and faster pace particularly underpin work in future chapters. The next chapter will consider how suicides affected prison healthcare staff, and therefore those in their care, in the constrained context of 21st century prisons in England and Wales.

Chapter 5: Prisoner suicides: exploring healthcare staff experiences and enduring impacts

Please note: this chapter contains detailed descriptions of prisoner suicide and self-harm that readers may find distressing.

Introduction

This chapter builds on the previous chapter's conceptualisation of governmental factors that have contributed to pressures, paucity and pace in prison healthcare, as correlated with prisoner self-harm and also, prisoner suicide. It also draws on critical suicidology and social work literature to help illuminate structural and organisational contributory factors to prison deaths. Prisoner suicide can cause contemporaneous and delayed impacts on prison officers, generating upset, distress, feelings of failure, vivid memories (Crawley, 2004a), as well as shock, guilt, disappointment, depression and anxiety (Liebling, 1992). Prisoner suicides are 'in considerable part influenced by the nature and quality of the prison environment' (Liebling, 2017: 22), and differences in prison moral quality affect prisoner outcomes, 'for example, better treatment leads to higher wellbeing, lower distress and fewer suicides' (Auty and Liebling, 2020: 359). Data from this study builds on extant scholarship to advocate for the increased visibility of the governmental factors that affect prison moral quality and the environments which influence prisoner suicide and self-harm. Prison healthcare staff described the frequency and range of suicides, managing their own sadness and guilt after suicide, whilst they kept working. Suicide attempts could also evince enduring feelings and memories for healthcare staff. It was an original finding of this study that staff reported the diminished dignity of dead prisoners, due to perfunctory death reporting and prison constraints, leading to moral injury in staff. Prison suicides were reported as potentially preventable, citing the prevalence of the known risk factor of prison transfers, causing a further loss of hope in staff. The lack of adequate resourcing made ACCT processes hard to implement and constrained professional curiosity: consequently, this limited staff's ability to prevent suicides. Therefore, this thesis argues that some prison suicides should be more appropriately named as 'induced self-violence' (Aitchison, 2024: 905), to help highlight factors located outside the suicidal prisoner or the healthcare worker: offering a novel contribution to knowledge. This is congruent with the processual ontological frame of this thesis, which

posits the interconnected and dynamic nature of things, providing generative alternatives to narratives of over-responsibilisation in any one person.

Data in this chapter expand the prison epistemology of suicides, thereby aiding the erosion of testimonial and hermeneutical marginalisation; in so doing, helping address epistemic injustice. As outlined in Chapter 3d.iv regarding inclusion and exclusion criteria, participants did not need experience of completed prisoner suicide to participate. The majority of staff in the sample, 24 of 28 participants, had encountered at least one completed suicide in their prison health work. Of the four that had not, three had had direct emergency responder interaction with a prisoner who attempted suicide, who required cardio-pulmonary resuscitation (CPR) or other serious intervention to preserve life. In both the specialist knowledge and managerial cohorts of participants, many had previously worked in prisons in a frontline healthcare role, so used their own historical experiences of suicides from frontline work, alongside contributions from their current perspectives. This chapter is makes space for their experiences of prison suicides to be explored and understood, to be made visible as part of an extended epistemology.

5a) Prisoner suicides: exploring healthcare staff experiences

5a.i) Methods and 'the more violent, the more upsetting'

Staff cited people most commonly dying by ligature and outlined a range of less usual methods of prison suicide, finding some methods particularly distressing. Prisoners dying by suicide most commonly die by hanging (Shaw *et al.,* 2004). Findings from this study corroborated this, though data here also contained examples of self-immolation, self-suffocation and deep or arterial cutting in a variety of locations on the body, that caused bleeding out. Suicides of any method created potentially significant impacts for staff. Drew explained:

> *'I think ligature is still the commonest, but we've seen successful overdoses. We've seen people cut themselves, cut their necks and exsanguinate. We've even seen a case of electrocution. [….] But you know, finding someone hanging is going to affect you...'*

Drew (C, former prison doctor; national manager, prison health)

The category of ligature included ligature deaths or attempts without suspension, not just those who were hanging. For example:

> *'… he didn't have anything to suspend from, and the way that he did it was laying on his tummy and put something around his neck and then lifted his legs up at the back and, um, and attached the ligature to his feet and slowly pulled on his feet, um. And it was just enough then for him to go unconscious and when he went unconscious, your body relax. So, it maintained the ligature pull. And he went that way.'*
>
> Riley (A, former RGN and senior healthcare manager)

Data demonstrated that ligature-related deaths, although most common, could still be upsetting for staff. Wider prison staff cohort studies show staff find suicides distressing (Borrill *et al.,* 2004), as do prison officers studies (Barry, 2017). Data from this study demonstrated suicide caused prison healthcare staff distress, irrespective of method.

Completed or attempted suicides with high levels of viscera and violence increased the likelihood of staff distress and potential trauma. Other studies identify factors that increase likelihood of trauma as: staff's physical proximity to the death (Borrill *et al.,* 2004; Cassidy and Bruce, 2019) and those with prior experience of suicide (Borrill *et al.,* 2004; Cassidy and Bruce, 2019; Wright *et al.,* 2006). Those with an avoidant approach and a pessimistic outlook had an increased likelihood of experiencing post-traumatic stress disorder following a death (Cassidy and Bruce, 2019). Data from this study contained examples of prisoners cutting their own throats in attempted or completed suicide attempts. These were universally deemed as traumatic for staff encountering them. Drew noted:

> '*So, some of the more, almost the more violent, the more upsetting... '*
>
> Drew (C, former prison doctor; national manager, prison health)

Data contained sensory descriptions and highlighted the profound practical challenges of medically responding to someone who has severed a main artery, whilst slipping in their blood.

> *'…when she got there, he had actually um... cut his throat, his wrists and his elbow, his groin, his ankles. There was just blood everywhere. It was like dripping off the ceilings, off the sink, it was off the bed so... everyone went running in and they literally were slipping, the nurses and everyone was slipping cos there was so much blood. And anyway, they tried, there was a very difficult trying to keep him alive, trying to keep his head on. '*
> Chris (C, former nurse; senior health and justice manager)

> *'…she had attempted to strangle herself by using her bra tied to a hot water pipe […] she knelt forward and what she had thought in her head was - I'll do that and when they unlocked the door, they'll see me. What actually happened that day, for reasons I don't know, was the officers started unlocking from the opposite side, so she was the last person to be unlocked rather than the first person. So, by the time they got round and got to her, she yeah, she... we, we were close. […] They cut [her] down and she was she was unconscious. She had been doubly incontinent, so she'd lost control. I ended up with, I got the resus bag, I got Hotel1 to come down and we ended up having to intubate.'*
> Morgan (A, former RGN)

Completed or attempted suicides that involve staff contact with bodily fluids can be more traumatic and more contaminating, literally and metaphorically. Prison work can socially taint and/or psychologically taint those who undertake it (Lemmergaard and Muhr, 2012 and Garrihy, 2022 respectively). Data here suggest this work was physically tainting too. Suicide methods that involve more violence and viscera can be a contributory factor to distress and trauma in prison healthcare staff.

5a.ii) Staff initial responses: awful, sadness, guilt

Participants' experiences of completed prisoners' suicide across cohorts and timeframes was characterised as awful, tragic, terrible. This supports previous scholarship that states prisoner suicide can be 'devastating' for staff (Liebling, 1992: 195), can have 'catastrophic effects on well-being' (Banwell-Moore *et al.,* 2022:2), and, in some cases, result in trauma and post-traumatic stress disorder (Cassidy and Bruce, 2019; James and Todak, 2018; McKendy *et al.,* 2021; Wright, 2006). Participants in this study cited the impacts throughout prison staff types and grades, yet data also suggested distress was compounded not just by physical proximity, but also by *relational* proximity to the prisoner who died. It was not only staff who may have been involved in a resuscitation attempt that experienced profound impacts. Those who had previously worked with the prisoner, or historically made crucial decisions regarding their care, that is those who had relational proximity – even if no longer current – could experience deep distress following prisoner suicide.

Awful

Participants from the specialist expertise and managerial cohorts most directly articulated these deleterious impacts for staff.

> *'It's the nightmare. It's their worst nightmare. Nobody wants a death. Nobody wants somebody to kill themselves. Nobody wants to be the one that responds to that.'*
> Alex (B, senior prison health expert and prison doctor)

> *'Always terrible. And particularly in people they've had a lot of involvement with, but obviously even ones they haven't, they may be on the team that goes to deal with the actual resuscitation and all that. Whatever level of involvement, I think it's awful and I think the[re are] stages of awfulness.'*
> Rene (B, senior national role, health and justice)

Data highlighted the impacts on the *whole* team of the anticipation of suicide, as well as the aftermath, on their lives both inside and outside of prison. Data also showed a glimpse of healthcare staff as human beings managing their emotional reactions, as well as professionals with a job to do. Data demonstrated how grim prison suicides could be for healthcare staff.

Sadness

Staff's early emotional responses to prisoners' suicides are well documented: officer staff can be upset by prisoner suicides (Barry 2017; Borrill *et al.,* 2004; Ricciardelli *et al.,* 2020). Suicides can cause distress (Crawley, 2004a) and shock, guilt, disappointment, depression and anxiety (Liebling, 1992). In parallel medical literature, patient suicide creates significant emotional impacts for doctors and nurses including sadness, grief, shock (Malik *et al.,* 2021) and sadness, anxiety and guilt (Gibbons *et al.,* 2019). This study corroborated feelings sadness, shock, grief, and guilt, in some cases connected to the incongruity of suicide whilst performing a job that is meant to preserve life. Participants recalled their sadness:

> *'And so that creates sadness. I think it creates... you stupid, stupid boy, you know, it creates anger, it creates sadness.'*
> Chris (C, CEO prison healthcare provider)

Physical proximity to death is indicated in poorer outcomes for staff following prisoner death, e.g. those staff who delivered cardio-pulmonary resuscitation (Borrill *et al,* 2004). Findings from this study suggest *relational* proximity also heightened feelings of sadness. Some participants went further describing their grief processes, with memories evoking emotional responses during the interviews.

> *'The individual suicides where I have known the patient and had more of an interaction, they, they, they really, really saddened me. I'm kind of almost finding myself in tears here, thinking about a chap who... who... was very, very intent on, on ending his life.'*
> Lee (B, senior prison health expert and prison doctor)

Lee struggled with verbal fluency at this point in the interview due to their upset. They suggested that the regular, ongoing contact with this patient on their weekly ward round – their relationship – was why this suicide had so saddened them. Prison healthcare staff may have named and/or minimised their responses to prisoners' suicides as sadness, but data suggests many of them experienced grief and bereavement responses, which were salient,

ongoing and not easily consigned to history. Positively, this demonstrated staff's emotional connection with themselves and those they worked with. It also demonstrated the availability of grief from past events in the present and could be a potential indicator of unacknowledged and therefore, disenfranchised trauma.

Guilt

The other immediate emotional response prevalent in the data was guilt: about actions or omissions in practice and a generic sense that one should have done more to prevent death. This suggests the findings of Liebling's 1992 study, where guilt was more prominent in healthcare officers (38%) than prison officers (21%) following prisoner suicide, are still relevant. Rumi commented:

> *'I definitely felt guilty after... I think, I don't think anyone can work with someone who then commits suicide and not feel guilt. Because I think, there's this feeling... Well, what I found myself doing was, was going back over, especially the lady who committed suicide from the inside, thinking what should I have done that could have prevented this? Is there anything that could have prevented this?'*
>
> Rumi (A, former prison counsellor)

This sense of guilt seemed to partially originate from staff's extensive rumination on what they could have done differently prior to the death: casting healthcare staff as omnipotent agentic actors and reinforcing the myth of individual responsibility for deaths. Accountability easily morphed into guilt and self-chastisement about actions they "should" have taken. However, other staff were able to articulate that, despite their responsibilities to prisoners, despite the profoundly uneven power dynamics between the incarcerated and everyone else, that staff were *not* omniscient and their individual actions could not prevent all suicides.

> *'… there's something very secretive about the whole thing [suicide] […] you wonder - could he have been admitted sometime later? Or something like that, would that have been enough to have stopped him acting on his sort of behaviours? You know, but just it's all unknown, isn't it? I mean*

everything is unknown.'

Hayden (A, former prison nurse/healthcare officer)

'I can't say it shouldn't have happened, cause I don't know what was going on for him at that particular time.'

Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

Fin's response here indicates their view of the prisoner as an agentic person, who was changing and responding moment to moment, Liebling's (2019: 201) 'experiencing subject'. This is indicative of a 'morally tolerable' prison culture, where prisoners are treated as emergent people, not just as static, experienced objects (Liebling, 2023: 1), suggesting staff in morally tolerable prison cultures may experience less guilt in relation to their culpability for prisoner suicides. Guilt expressed by participants was connected to questioning the practitioner's own professional competence and ruminating on the period immediately before the death of the prisoner. Even when participants had articulated awareness of governmental factors contributing to prisoner suicide, in reflecting on the aftermath of death, the focus quickly became responsibilising individuals. Awfulness, grief and guilt were experienced by healthcare staff in the immediate aftermath; data suggested grief and guilt lingered which influenced staff in the present.

5a.iii) Staff ~~"keep calm and~~ carry on", despite distress

Irrespective of complex feelings arising in the immediate wake of a prisoner death, most staff carried on and completed their shift, whilst denying and deferring their emotional responses. This supports findings from parallel settings. One study in a psychiatric setting, reported staff had little chance to pause following a patient suicide, maintaining 'business as usual' (Awenat *et al.,* 2017: 104). Paramedics have been shown to 'supress internal distress… and force oneself to continue working' following attendance to a person who has died by suicide, predominantly due to macho work cultures and time constraints (Nelson *et al.,* 2020: 7). This work extends this extant literature to a prison setting. A study of senior prison staff that found perceived pressure from others prevented them leaving the shift following death by suicide (Gaschino *et al.,* 2022). This was not a reason cited in this study. Prison healthcare staff in this study gave two main reasons for carrying on: the internal motivation – a desire not to

compromise other prisoners' healthcare by leaving the shift and the external reason – that the healthcare provider could be in breach of contract should staff leave.

Staff in this study described suppressing or compartmentalising their own processing, they:

> *'…. put things to one side really and just get on with the practical stuff.'*
> Fin, (A, former RGN, Head of Healthcare, Regional Operations Manager)

This postponing of emotion is further explored in the following chapter. Healthcare staff were managing their emotional responses whilst interacting with and supporting bereaved colleagues and prisoners. This created an emotional juggle as prison healthcare staff were often in shock and trying to grasp unfolding events themselves. Staff recalled:

> *'…you're trying, you see other prisoners walking around. You're trying to kind of... comfort them in - obviously appropriately. You don't really know what's happened or why, it's all very new and you hear a lot of different things going around so, I guess, [you're] trying to make sense of what happened…'*
> Frankie (A, former prison psychologist)

> *'…you've got to then go out and manage other prisoners, you know, cellmates on the same wing, as well as going through your own personal, emotional feelings around what's happened.'*
> Hilary (B, senior national role, health and justice)

Although staff were clearly affected by prisoner's suicide, many were cognisant of the needs of other prisoners that would go unmet, should they go home and not finish the shift. This internal motivation prevented them from leaving, therefore protecting them from potential moral injury, but raising questions about their capability for work following such profound events. Frankie reflected:

> *'But for me to manage it, I needed to just carry on with my day. And I had a session booked in with the lady that morning, who I didn't want to cancel, for*

various reasons, but it was important really to see her. I also understood that there was an option for me to have all these things cancelled and do what I needed to - go home, whatever, but that was the right thing for me to do…'
Frankie (A, former prison psychologist)

Prison healthcare staff deny and defer their emotional responses to suicide whilst navigating the practical aftermath too. This study brings along extant knowledge from parallel settings by highlighting the primacy of insufficient staff, resources and time in how prison healthcare staff feel able to react: the low contractual minimums explored in 4c.ii, are relevant here. Not finishing a shift and therefore not delivering the healthcare anticipated could lead to transgressing a professional boundary and potential moral injury. Staff continued with work irrespective of the personal cost.

The other reason participants gave for staying on site after a prisoner suicide was an external one, healthcare providers' contractual staffing minimums. Data here provides a practical example of governmental factors, in this case the 'savage' budget cuts due to austerity (Crewe and Liebling, 2017: 842), controlling staff's choices in their response to prisoner suicide, limiting their agency because of a lack of colleagues. This participant had also worked as a clinical reviewer and reflected on an experience they had whilst undertaking this role:

'I remember two male nurses who had attended an incident [… they were] crying as they recounted events. […] Whilst the PO [prison officer] was clearly affected by the events, he was able to speak about it in a reflective way, whereas the nurses were still very obviously upset. They said they had no immediate support from their manager and could not leave the shift early as there weren't enough staff to cover them. Managers based in the Trust were off site and contacted the two nurses a few days later once one of the nurses requested support and an incident report had been logged.'
Morgan (A, former RGN) – written communication following interview

Despite their experiences and distresses, the nurses in this account had to stay on site because there was no contingency in the healthcare staffing provision that would allow them to leave

early. This demonstrates how staff's experiences of prisoner suicide go unacknowledged and provides an example of how disenfranchised trauma, explored in chapter 4, can occur. In contrast to the healthcare staff, prison officers were deployed from other parts of the prison to provide cover and, in this instance, were well supported by a reactive prison management. The off-site location of the healthcare trust's managers affected their ability to swiftly and appropriately respond to their nurses' needs. The physical distance of the managers highlights another negative impact of savings-driven prison healthcare commissioning, as discussed in chapter 4. The paucity of staff on shift mean distressed staff may *have to* carry on. This evoked Auty and Liebling's (2024: 742) description of morally deprived prisons, 'places where we don't matter', "we" here referring to staff, which then create 'distress, anger and risk' for *all* those living and working in the prison. Staff who had to "carry on" then developed strategies to enable them to do so, which is further discussed in the next chapter.

Just "carrying on" can affect staff and impinge on capability. Participants noted that serious adverse events were responded to differently by other industries outside healthcare, highlighting the possibility of another way of doing things. There was more space, time and acknowledgement and therefore less potential for disenfranchised trauma:

> *'You gotta get back out. You gotta get through your whole shift and do your day job. And I know that's not different to anywhere else where that potentially could happen, but it's still just that impact of you have to act as if nothing's happened whilst still trying to process it all. And we are humans at the end of the day, and I know in healthcare we always talk about we need to adopt the airline model of investigation and root cause analysis. If anything like that happened in the airline industry you're taken out of duty for two or three weeks, while all that happens. But in healthcare we just have to get back up, get back into it, carry on with the shift and process it all at the same time* […] *And there's something about that... does that alter your decision making for the rest of your shift because you're still processing it?'*
> Lee (B, range of senior health and justice roles, prison doctor)

Healthcare practice for the rest of the shift could be affected as the practitioner struggled to juggle their internal world and their external responsibilities within their prison work. There is a lack of physical space in prisons for staff to acknowledge, process and/or decompress after a serious incident. Unlike other professions dealing with intense, potentially high-risk scenarios, there was little chance of retreat during the working day, e.g. social workers in their car between appointments (Ferguson, 2016). The lack of physical and emotional space can exacerbate healthcare staff distress. Their experiences and needs often go unaddressed, as does their *humanity*, in what can be a morally depriving work environment without the emotional or physical space to acknowledge these. This can contribute to disenfranchised trauma (see section 4d) and negatively affect staff's ongoing work with suicidal and self-harming prisoners, explored in chapter 6.

5a.iv) Enduring distress after life-saving interventions

Prisoner suicide *attempts*, not just completed suicides, can create significant and enduring impacts for staff. Other studies note, 'multiple participants indicated that discovering an attempted death by suicide was a particularly stressful event—for some, the most stressful event they had experienced in their career' (McKendy *et al.,* 2021: 6). Direct involvement with attempted or completed suicides has been identified as a risk factor for experiencing trauma following a fatal or near fatal incident in prison (Borrill *et al.,* 2004; Cassidy and Bruce, 2018). In this study, there were detailed accounts of life-saving interventions, some which were recounted 20 years later, e.g. describing CPR processes, the emotions experienced, the time of day. These memories are salient and available in the present. Data from this study extends extant literature to highlight the importance of *relational* proximity to the prisoner in understanding any impacts on the staff member, and not just the physical proximity of staff in relation to suicide.

Even when lives were saved, staff could question their competence. This former nurse narrated her experience of cardio-pulmonary resuscitation:

> *'I went straight in first. We moved her off the bed onto the floor. She wasn't breathing. You know there was no breath coming and an officer did mouth to mouth and I did the chest compressions. And she, at some point, took a breath.*

I've never done that. I've never, ever done it in any other… Never done it before and I've never done it since. So, don't know if I did it right?! In fact, I broke her rib. She was like "you broke my rib!" and I was like, "well, rather that than you'd be dead!" and she just hugged me. She didn't want to be dead either.'
Ashley (A, former RMN and senior healthcare manager)

For this participant, administering CPR was a once in a career event. Despite saving the woman's life, they still recount their doubt over whether they 'did it right' and the high stakes and stressfulness inherent in that situation. Slade *et al.*'s review identified professionals experiencing a 'crisis of confidence' in relation to 'professional competency, either actual or perceived' following a completed suicide (Slade *et al.,* 2019: 34). This finding is relevant here, even when the nurse's actions preserved life, they questioned their competence. The description of the prison officer giving mouth to mouth and the member of healthcare staff administering chest compressions – teamwork resulting in a life saved – illustrates a theme that recurred repeatedly in the data: the importance of team work for prison health to function, inherently rejecting individual responsibilisation. This was a finding of this thesis across all cohorts of participants, be it within multi-agency healthcare teams or between healthcare and custodial and/ or administrative staff: strong cross-silo relationships and teamwork improved prison healthcare.

Data contained other graphic examples of staff feeling traumatised *at the time* and *enduringly* by a suicide attempt. This former nurse narrated a lifesaving intervention 15 years previously:

'I walked into his cell and he'd had a real good go at slashing his own throat. And I was knelt on the floor in a pool of his blood with my fingers in his... [laugh/exhale], fingers in a hole in his throat, in the side of his throat. He'd missed his, he, he missed his carotid artery by millimetres. He went out and got stitched up. But there was a lot of blood and blood up, blood up to me elbows [laughs] and all over me, all over me uniform.'
Charlie (A, former RMN)

The difficulty of describing these events led to the participant laugh in their narration of them and repeat words as they struggled to get through the recollection. As discussed earlier in this chapter in 5a.i, this was a violent attempt involving viscera which created enduring impacts in the present day. The participant cited this incident as the beginning of their journey to leaving prison healthcare, they also reported nightmares and were clearly moved by the retelling of the incident. The prisoner's life was saved, yet the staff member's life was still changed by the experience. Another example highlighted how these experiences enduringly shaped and travelled with staff:

> *'And I remember speaking to him at the meds hatch and I could just tell he wasn't himself… I got a call later then, code blue, and went to their cell […] they'd made a pact to kill themselves together, and they were hanging side by side, holding hands. Um. We managed to get them back… yeah, that's one that's stayed with me [...] It can be very difficult. One of my patients had a learning disability and… he was on constant watch at the time, because he was constantly trying to do things to end his life… he was in a body belt and we were constantly reassessing, "right, he's deescalated a bit now... Let's try it without". And then he would just kinda go back up. So that was quite an exhausting night shift […] I remember one chap, he was on an ACCT but he'd slit his wrists going to bed. And just spent the whole night bleeding out... I remember getting to that cell door and going – ohhh, right, oh OK. This is a serious attempt. He lived.'*
>
> Riley (A, former RMN and senior healthcare manager)

Constant watch requiring ongoing physical interventions is exhausting (see also Coffey *at al.,* 1999). Emotional exhaustion is one of the early indicators of practitioner burn out (Boudoukha *et al.,* 2013; Lambert *et al.,* 2012). Suicide attempts are not always recorded in fast-paced prison settings, as discussed in chapter 4. However, they can be significant events for the prisoner and those who provide (health)care to them, creating enduring impacts that are manifest in the present as observable emotions, e.g. sadness and/or as hidden distress or trauma, e.g. nightmares. These data provide further evidence of how an already demanding

and stressful job can become even more challenging and relentless with little opportunity to process these potentially traumatic experiences, resulting in enduring outcomes.

5b) Diminished dignity - enduring impacts

5b.i) Custody compromises corporeal dignity after death

Both staff and prisoner dignity were diminished after death creating salient memories, enduring sadness and contributing to moral injury. Dignity is conceptualised as the fundamental worth of all people equally (Debes, 2017), which is revealed in the way humans treat other human beings (Skinns *et al*., 2020). Dignity is 'contingent, comparative… and contextual… is experienced, bestowed, or earned through interaction in social settings' (Jacobson, 2007: 294): a relational and dynamic concept. Prison settings create particular difficulties when suicide happens. Even after death, prisoner dignity may be diminished because of the well-documented tension between care and custody (Crawley, 2004a; Liebling *et al.,* 2011; Tait, 2008) or prison cultures that objectify prisoners, minimising their personhood (Liebling and Ludlow, 2016; Liebling, 2019). This diminishing of dignity exacerbated staff distress and potentially contributed to moral injury. Prisons and secure settings are homes and places of work (Crawley, 2004b). Additionally, 'all deaths in custody are treated as suspicious by police' (Ministry of Justice, 2020: 56). Therefore, when there is a suspected suicide, staff secure the scene, then must leave the body and wait for the police before they are able to take any further action (Tomczak, 2018). This custodial reality can create further internal conflicts for healthcare staff, wanting to care for the dead body but being prevented from doing so. This former nurse explained:

> *'I suppose, the worst part about it […] is because when you do your nurse training […] they spent a great deal of time telling you about how to cater for people in life and death. […] that whole last rites thing, about just making sure that people were clean and tidy and presentable […] But you can't do that in prisons. Because there's that whole thing about well, it might be that they were murdered, and there's a whole police investigation so... I… we all had to walk away from that man who looked terrible, that young boy looked*

terrible and we had to leave him as he was until the coroner came and took him away […] *And I was talking her [governor] through it and she said – "well, why didn't you do something?" And I said, "because we're not allowed to." We're not allowed to, you can't, we couldn't give him a wash and just make sure that he at least looked a little bit clean and tidy, we had to send him back out the door the way that he was the day we found him, or the time that we found him and it was just... terrible, but anyway. '*

Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

Penal power overruled the agency and standards of the nurse creating an enduring visual memory of the deceased person. Being unable to follow normal nursing practices post-death transgressed a professional boundary, which contributed to moral injury and diminished the dignity of the deceased.

It is a clear finding from the dataset that staff were distressed by the prison environment constraining their ability to do their job; diminishing prisoners' dignity and minimising prisoners' humanity. Staff expressing this were demonstrating treatment of prisoners as 'experiencing subjects', even after death, indicative of staff cultures that created enabling environments with emergent possibilities for those incarcerated therein (Liebling, 2019: 201). These constraints on staff attending to the bodies of dead prisoners extended the consequences of imprisonment, compromising prisoner bodies directly and indirectly. This was upsetting and, at times, confusing for staff. In this example, the dead body was juxtaposed with the pedestrian nature of quotidian prison life.

'And then it's just about kind of compassion. I always find it really difficult cutting someone down, laying them out and then, you know, if it's in the middle of the night or even in the day, you just lock the cell back up and then kind of wait for the coroner to come in… in the meantime, someone's son, brother, father is just lying on that... cold... floor [takes deep breath] ... And um, you know, everyone else is just milling past on their way to get breakfast, or use the phone, or go off to work or education.'

Riley (A, former RMN and senior healthcare manager)

The prison setting indirectly diminished the dignity of the dead body: the noise, the routines of daily life go uninterrupted. The humanity of the prisoner is highlighted by this participant, grounding the identity of the deceased in their familial relationships and not, for example, in their diagnoses or crimes. Leaving the body where and as it is until after the coroner has been, created distress for staff. The prison setting also impinged more directly on the bodies of the deceased. In this example, underfloor heating kept the deceased's body warm and led to confusion about whether their life could be preserved.

> *'… the chap […] had passed significantly before we... Because it's under floor heating... had prevented the rigor mortis process setting in earlier. That was interesting. Because I think the nurses attended and the officers were like – "he's still, still warm" and the nurses were like "he's, he's gone" […] as the nurse had turned him over, he was solid then in that respect. Yes, was pretty dead. But yeah, when the officers first got to him, I think they thought there might be something we could do here because he's, he's not sterile cold.'*
> Casey (A, former head of healthcare)

The finality of how the body is treated after death and not being able to enact professional standards because of the prison setting created vivid, enduring memories for staff and is a novel finding of this study. It also provided another example of prison healthcare practice that may result in moral injury for staff.

5b.ii) Communication about prisoner deaths

How prison healthcare staff found out about a prisoner's suicide could be foundational in their response to it. This was a discrete finding for those frontline healthcare practitioners not in emergency responder roles. There were outliers in the data, occasional examples of timely and sensitive communication; but most data showed methods of staff being informed about prisoner death ranged from cursory to non-existent. This further distressed staff. A study of psychiatrists on an inpatient ward found how they were told about patient suicide increased or decreased their distress (Awenat *et al.,* 2017). This study extends this finding and applies it to prisons and across a broader range of healthcare staff. Data from this study demonstrated

that how staff learnt of a death also illuminated both the quality of relationship between different parts of the healthcare workforce in prison and the quality of relationship between healthcare management and staff. Treating staff with a lack of respect or dignity created negative emotions and meant staff are then more likely to treat prisoners disrespectfully (Liebling with Arnold, 2004). Not all participants worked full-time in the prison, some were subcontractors to the main healthcare contractor: this increased the likelihood of them stumbling upon, rather than being informed about a death. One prisoner may be involved in many interventions by different staff and it can be difficult to know who needs to know about a death. Based on chapter 4's findings of the fast pace of prison healthcare and the paucity of staff creating significant time pressures, it is unsurprising that poor communication to staff of prisoner deaths was reported. Staff shared their stories:

> *'I came into a death in custody notice that was literally pinned on the key cabinet. This is how you find out someone is dead in prison […] I think that in and of itself, like how you are told people have died is very hard...'*
> Sullivan (A, former frontline VCS healthcare worker)

Pinning up a death in custody notice may be an efficient way to communicate to large numbers of staff in a busy prison, it is also distant and perfunctory. This method of communication contributes to minimising a serious event, diminishing the dignity of the deceased. A piece of paper mediates the news of death, creating distance and providing no support for those receiving the news should they need it, thereby leaving their humanity unacknowledged too. This method of communicating prisoner suicide to staff created additional harm and diminished the dignity of staff and the deceased prisoner.

Prisons cultures characterised by secrecy and poor teamwork also limited sensitive communication with staff, even with important information like prisoner suicide.

> *'One of my major complaints, because things would happen at the prison the whole time and I'd end up learning about them from the clients! And there's such a culture of keeping everything secret. And because these things are going to be investigated, it's like – who tells you what's actually going on?*

Somebody killed themselves and I, I'll find that out from the client...'
Rumi (A, former prison counsellor)

Information sharing between teams could be sporadic and the way staff heard about a death was inconsistent, with much depending on the strength of teamworking in a particular institution. Another staff member talked about how confusing it was, coming into work after a death and not being able to comprehend the information.

'I went into the office and everything was just very dark and everyone just looked very... sad and I didn't really understand […] her key worker was in the substance misuse team, was in the office... and she was like distraught by the whole thing and someone mentioned something. It took a while to connect that she was then my lady, the lady who I'd done an assessment with um... I didn't really understand... It kind of took a while for it to sink in…'
Frankie (A, former prison psychologist)

The sense of confusion lingered in the narration here and it is not clear precisely how this participant was told about the death. The impression that remained was the distress of other team members in amongst the sadness and darkness, alongside the struggle to grasp that there was a suicide and it was a prisoner this practitioner knew. Secrecy and confusion marked staff experiences of learning a prisoner they worked with had died by suicide.

There were outliers in the data. One non-emergency responder shared an example of good practice when being informed of a death.

'The one good thing that came out of that, for me, was that probation found out that that had happened, and they knew I'd been working with her and they came and told me. And I thought that was a beautiful example of the network that was around her. I didn't just "find out".'
Bobby (A, former prison psychotherapist)

In this case, a redeeming feature of a bleak situation was the care that this practitioner experienced in their colleagues seeking them out to ensure they knew about the person's suicide. The suicide had still occurred, but additional harms were mitigated by sensitive communication. This demonstrated the potential through a small act to significantly affect outcomes for another person *without* significant structural change. The data excerpt above from Bobby was unusual, contrasting sharply with a usual lack of acknowledgement of staff's humanity and the potential for grief, guilt and other difficult emotions following a prisoner's suicide. Perfunctory communication can set an expectation that staff responses should be likewise – brief, minimised and detached – with no support for more complex or distressed responses. Utilitarian, pedestrian death notices and staff uninformed due to penal secrecy both reduce the gravity of prisoner suicides and contributed to its normalisation. This then minimised prisoner suicide: diminishing the dignity of the deceased and that of the staff learning of it, leaving less space for acknowledgement of the death and/or the emotional and physical responses to it.

5c) Suicides were potentially preventable

In over-crowded, under-staffed prisons with acute, complex prisoner needs, participants saw prisoner suicide as too often potentially preventable. Within these prison conditions poor attention to known risks and unimplementable procedures designed for a different era constrained prevention. These constraints were partially driven by the context of austerity-based policies since 2010 (Ismail, 2023). The impact of government austerity policies and the 'need to make savings' has led to a 'tragic decline' in penal order, practices and outcomes (Crewe and Liebling, 2017: 849). This policy context created governmental factors that, as with prisoner self-harm explored in chapter 4, contributed to catalysing prisoner suicides due to staff's work pressures, pace and the paucity of resources. Indeed, critical suicidology scholars have questioned the use of the term "suicide" where its use 'obscures the role of structural violence and enables denial of responsibility from violent state policies by blaming the victim': another example of responsibilisation in practice. (Mills 2018; 315). The policy context that led to acute pressures on staff time, disabled prison healthcare staff's professional curiosity. Social work theory cites structural reasons for deaths, "invisibility" and compromised

professional curiosity (Ferguson, 2016). This thesis uses this scholarship to illuminate the governmental drivers of prison suicides. Systemic, governmental factors, chiefly under resourcing, could lead to known risk factors being overlooked, the ACCT process being poorly used and suicidal prisoners given scant attention. Staff gave many examples of suicides that they emphatically felt 'didn't have to happen' (Bobby, former prison therapist). Given the connection between resourcing pressures and effective suicide prevention, there is consideration of whether these suicides would be better categorised as induced self-violence. Induced self-violence is defined as people undertaking acts of self-violence, e.g. self-harm or suicide, 'in the context of a degraded psycho-social environment imposed upon them by a more powerful agent where it can reasonably be foreseen that such acts would result' (Aitchison, 2024: 908). Therefore, remedies are not solely located in individual staff or prisoners in England and Wales. The processual ontological lens this thesis uses eschews individual responsibilisation and considers a broad range of dynamic (f)actors, across scales as part of prison suicides and their prevention, e.g. from the Justice Minister to the broken prison cell bell. The following section has three subthemes regarding suicides as potentially preventable and how this affects prison healthcare staff: the presence of known risk factors causing staff despair and hopelessness, inadequate policies and procedures – ACCTs, and the governmental factors that constrain professional curiosity.

5c.i) Presence of known risk factors (prisoner transfers) engenders staff despair

Completed suicides of people with multiple known risk factors created feelings of despair in staff. Staff across cohorts in this study narrated events that led up to suicides, giving examples of known risk factors such as expressing suicidal ideation, having recent suicide attempts, receiving a long sentence or being transferred between institutions. Prisoner transfers between wings, but particularly into new institutions, are a known risk indicator for prisoner suicide (Marzano *et al.,* 2016; Rivlin *et al.,* 2013; Suto and Arnaut, 2010). Prisoners newly received into prisons are most at risk in the first seven days after arrival (Shaw *et al.,* 2004). Communication difficulties and poor information sharing within prisons between teams, between prisons and with external agencies, contribute significantly to deaths (HMPPS, 2021; Ludlow *et al.,* 2015; Tomczak, 2018). This study agrees that prisoner transfers are a risk for suicide and poor information transfer exacerbates an already risky event. Additionally, staff could be particularly affected by deaths of people with known risk factors, especially if the

staff were involved in prevention attempts. The presence of major, multiple risk factors meant suicides were arguably more *predictable,* and therefore more *preventable*, but prisoners still died. These experiences created despair in staff, curtailing their hope.

Prison healthcare staff expressed frustration, anger and despair at suicides deemed preventable. This participant shared an example from 20 years previously of a woman who had received a long sentence, been recently bereaved and been separated permanently from their children:

> *'She was transferred very, very quickly, um, from Prison B to Prison C and she hanged herself there quite quickly […] I think that the whole thing was mishandled. Terribly. […] And she was massively at risk […] it was, it is a tragedy. Didn't have to happen.'*
> Bobby (A, former prison therapist)

Despite the passage of time, Bobby still felt acutely about the death, pondering what happened the child of the deceased, because they felt the suicide was profoundly preventable. Another participant who reviewed suicides across prisons over a commissioning area retrospectively was angry and frustrated by the multiple acknowledged risk factors, including prisoner transfer, that resulted in a completed suicide.

> *'… and it was a very risky man, very high profile, very serious charges, previous suicide attempts, he'd come from another prison who said this man is a very high suicide risk at the point of sentencing. He went to [location] prison, got sentenced, took his own life that night […] Because it was a catalogue of disaster and there was, you know, <u>all</u> the warning signs in terms of suicide risk were there for that gentleman.'*
> Max (C, former RMH nurse; senior health and justice lead)

Staff cited strenuous, extraordinary efforts to handover well during transfer to ensure prisoner safety. In this example, these efforts were ignored with deathly consequences. Lesley recalled:

> *'… we transferred a patient to another prison and we told the healthcare team in that prison that he needs to be in the healthcare unit for the following reasons. And they didn't follow the advice and they put him on general location. And he, and he ligatured. And I know that the staff in the In Reach team and the healthcare unit, were very upset about the fact that they've done everything they could, to handover to the other service, they did what they needed to do and their advice wasn't followed. There was like a head of healthcare to head of healthcare conversation and none of that was followed. So, I know there's a couple things like that, that staff, they get angry about.'*
> Lesley (C, former RMH, senior national health and justice manager)

Lesley clearly highlights that staff in the sending prison were left 'very upset' and 'angry' by (another) preventable suicide. Harms from prisoner deaths radiate through all those working with them (Banwell-Moore *et al.*, 2022). In addition to processing the awfulness, sadness and guilt, staff experienced anger and despair due to the potential preventability of suicide when known risk factors, like prison transfers, were present.

5c.ii) Inadequate policies and procedures – Assessment, Care in Custody and Teamwork (ACCT) failure

Prison healthcare staff drew attention to the discrepancy between policy and practice, particularly the constrained use of ACCT (Assessment, Care, Custody and Teamwork) processes, in the current prison permacrisis. In pressurised prison settings, divergence can occur between written policies and procedures and their implementation, on occasion there is failure to implement with deathly consequences (Doyle and McGrath, 2016). ACCT processes were implemented nationally in 2007 to identify and mitigate prisoner self-harm and suicide (Pike and George, 2019). Stephen Shaw's review into the cluster of suicides at HMP Woodhill found that 'ACCT was designed at a time when the number of staff in prisons was significantly higher… and… the prison population was significantly lower' (Shaw, 2017: 36). Findings from this study corroborate and extend Shaw's findings from HMP Woodhill and demonstrate their relevance across the wider prison estate in England and Wales. Tomczak (2018: 109) argues prison staff are 'set up to fail' with regards to the use of ACCTs, stating 'Prison Service Instructions and Orders protect the MoJ but do not enable staff to protect

prisoners'. This study agrees. Staff were often unable to engage with ACCT processes as they were intended, due to the pressures, paucity and pace of the work and healthcare's reliance on the custodial regime: e.g. the complexity of convening a multi-agency meeting. This section now explores the constraints on prison healthcare staff use of ACCTs and the consequences.

Workplace pressures could stymie the use of the interdisciplinary ACCT processes. Prison work cultures can make good interdisciplinary collaboration more or less likely: Crewe, Hulley and Liebling's (2011) conceptualising of traditional-resistant prison cultures, marked by cynicism, disrespect and control, do not lend themselves to encouraging multidisciplinary decision making, grounded in trusting professional relationships and may therefore hamper suicide prevention efforts. ACCT was designed as a fundamentally a 'multidisciplinary collaboration' that required communication to achieve 'collective objectives' (Ludlow *et al.,* 2015: 46). However, practice does not always comply with policy. As Shaw (2017:36) noted, this is problematic: 'To put it at its mildest, it is not healthy for what is practicable to diverge so wildly from what is described as a mandatory action in a policy document'. Data from this study demonstrated Shaw's finding for HMP Woodhill, can be extended and applied to many other prisons. This senior participant noted the lack of multi-agency working on ACCTs due to resourcing constraints:

> *'I know from when I worked in prisons the sort of – "Ohhh can we get to our ACCT review?", "Ohhh I don't think we've got time." That because of the pressures and clearly going to the ACCT reviews is really important if you're involved, that's how it should work, but often it's just the prison officer, and sometimes the prisoner […] and it's all a bit... simplistic really and not joined up.'*
>
> Rene (B, senior national role, health and justice)

Conducting ACCTs with only a prison officer and prisoner undermines their interdisciplinarity and therefore, their utility in suicide prevention. This was not due to a lack of *will* on the part of practitioners but was attributed to time pressures caused by insufficient resources. Ludlow and colleagues (2015: 33) showed the negative impacts of 'too few staff' on proactively managing suicide risks, including the quality of ACCTs. This study agrees. Data demonstrated

that a lack of staff and resources in the broader prison ecology negatively affected use of ACCT processes with poorer outcomes for prisoners. For example, the lack of prison officers led to over-use of in cell time and healthcare staff being asked to conduct ACCT assessments improperly. Sullivan commented:

> *'…the whole wing went on to bang up and there just were not enough staff to be able to do my job. I was kind of being asked to go and see my clients and do ACCT assessments through locked cell doors. I was unable to have my guys unlocked for group because there weren't enough staff to unlock to do group activities. And I think that was the combination of just the massive staff cuts in like 2012, spice coming into the prison and just a... general feeling of lack of safety within the prison.'*
> Sullivan (A, former frontline VCS healthcare worker)

Data contained tangible examples of the impacts on healthcare practice created by the benchmarking policy of 2012 and the officer staffing cuts. Healthcare staff often lacked the agency and/or resources to conduct assessments and convene processes stipulated by ACCT, which was detrimental to the quality and utility of the ACCT in preventing suicide.

Fewer distressed people in prison and/or more staff, more experienced staff and resources, would improve the use of ACCTs. Staff inexperience was correlated with lower scores on 'relationships with prisoners' and a lack of "jailcraft" in private prisons studied (Crewe *et al.,* 2011) In the current context, with high staff turnover and less experienced staff, ACCTs could be both over and under utilised. Prison healthcare staff knew there was not enough resource to open an ACCT for everyone who might need one if you followed the full multi-agency implementation of the process, so they were cautious in doing so. Crewe and colleagues' (2011) work demonstrated that inexperienced staff can lack 'confident authority' on wings, it is reasonable to extrapolate that to confidence in whether it is appropriate to open an ACCT or not, is part of this. A lack of jailcraft may create hesitancy in using ACCTs, whilst simultaneously, staff driven by risk aversion could open a proliferation of ACCTs, using them as 'procedural compliance', rather than an 'exercise in care': which also decreased their

efficacy (Ludlow *et al.,* 2015: 34). This participant explained the decision *not* to open an ACCT, despite the presence of known risk factors:

> *'I'd only had one session with her. I'd done an assessment. And she'd scored very highly on her psychiatry on her anxiety and depression scores, which is not uncommon at all. […] Obviously, I then explored with her, her suicidal ideations and plans, and she'd definitely got suicidal ideation, again not uncommon. But she was very clear that her plans were, she would not take her life, she was not going to attempt to take her life while she was in prison because she wanted to do it by drug overdose. That was her preferred method and she didn't, she didn't have the option to do that while she was in prison, and she was not going to be out for 18 months. So, I went and discussed it with the prison officer afterwards and we debated together whether to open an ACCT or not. We decided against. I think we made a note... […] And also put a note in the staff obs [observation] book, which the SO [senior officer] would see. Because obviously, I was thinking at that point that risk moment would be her release date and we would then need to make sure that she was, but that was a long way away. She actually killed herself two days later by tying a ligature. Um... Obviously, I wish with all my heart I'd opened an ACCT. As I'm sure the prison did.'*
>
> Rumi (A, former prison counsellor)

The participant expressed regret over not opening an ACCT, though there is no guarantee doing so would have preserved life. Indeed, the PPO annual report contains several examples of prisoners on poorly managed ACCTs, who then died by suicide (PPO, 2023). ACCTs can be presented as a panacea, despite the current complexities of implementation. The consequences of systemic issues, e.g. a lack of staff, then funnel down to individual workers making decisions that they then bear responsibility for when there is a completed suicide: responsibilisation rather than considerations of broader accountabilities. Whilst ACCTs have saved lives, their effectiveness is diminished in the current context. They can be over-used by those who are risk averse. They can be under-used for at risk people to ensure scarce resources go to others deemed more in need. Governmental factors, that have created

resourcing pressures, low staff numbers and less experienced staff unable to use confident authority in prison, led to impoverished and/or inconsistent implementation of ACCT and compromised its efficacy. These governmental factors that denigrated ACCT processes contributed to prison suicides.

5c.iii) Governmental factors constrain professional curiosity

Data also provided another example of governmental factors constraining prison healthcare staff: the pace of work limited staff's professional curiosity, hindering suicide prevention. Definitions of professional curiosity vary. Originating in social work and now used in a wider range of settings, including probation, most definitions encompass: practitioners gathering information, probing, reflecting and not simply taking the information presented to them at face value (Phillips *et al.,* 2022). Thacker *et al.* (2019) identified themes that prevent professional curiosity – case dynamics, professional issues and organisational issues, highlighting high work pressures and case complexity hindered curiosity. For example, a worker with a higher caseload than usual, resulted in a case that was not prioritised and slow responses, leading to death (Brabbs, 2016). Probation scholars found 'high workloads, a lack of time and a high turnover of staff' as barriers to curiosity, noting these factors are 'endemic' within public services in England and Wales (Phillips et al., 2022: 559). Data from this study provides a novel contribution to knowledge: professional curiosity in prison healthcare staff was stymied by over-burdensome procedures and organisational factors, e.g. pressures, paucity and pace. This resulted in prison healthcare staff who are 'bureaucratically preoccupied' (Ferguson, 2016: 1019). Staff then had reduced capacity for interactions with suicidal prisoners. Additionally, staff curiosity about prisoners, including their suicidality, can be shaped by whether their prison work culture conceives of prisoners as either 'experienced objects' or 'experiencing subjects… with emergent personhood', which determines staff treatment of prisoners and the moral climate of the institution (Liebling, 2019: 201). If personhood is emergent, there is the understanding that there is always something new to learn and curiosity can flourish. Where professional curiosity was stymied, it constrained staff's attempts at suicide prevention.

The organisational demands on prison healthcare staff prevent them fully seeing the prisoner and their needs, meaning opportunities for prevention may be missed. Child protection

scholarship demonstrates that in parallel situations staff are hindered by quick timeframes, high caseloads, the detailed recording of cases and other bureaucracy, as well as other procedural compliance requirements (Broadhurst et al., 2010). Ferguson suggests, the child may have become 'invisible' due to the 'combination of organisational processes and the dynamics of interactions with service users' meaning staff experience 'emotional and sensory overload and become detached' (Ferguson, 2016: 1008). This can lead to children being "invisible", or 'seen but not seen' (Burton and Revell, 2018: 1513). Data from this study demonstrated staff seeing but not seeing: seeing known suicide risks, but not seeing a prisoner at risk of suicide. This manager explained the tension between the presence of risk factors and the prisoner's presentation, e.g. what they tell the healthcare staff member about their intentions and/ or state of mind.

> *'… so, he was a guy that had been in the mainstream prison service and then had worked his way, I think he was on about a four year sentence, and he had worked his way to an open prison. And he had tried to take an overdose in the open prison. And so was automatically shipped back to where we were. He told everybody that he didn't know what he was thinking about it. That was a silly rash thing to do. He wasn't really feeling suicidal. "Oh my goodness", you know, "what a silly man I am" kind of thing. And he was under the mental health team and then without warning, he was in a camera-ed cell […] and the GP just happened to look at it and saw there was a dark patch on the floor.'*
>
> Chris (C, former nurse; senior health and justice manager)

In this example, it is possible that the prisoner may have been being entirely congruent in the moment that they spoke to the staff member, only to experience different feelings later. Indeed, 40% of suicide survivors said they had acted impulsively (Rivlin *et al.,* 2013). However, Chris's data included a prisoner transferred back to closed conditions, having made a suicide attempt whilst in open conditions providing two indicators for heightened suicide risk. Even with these evident risks, staff did not interrogate the prisoner's own pronouncements about his state of mind. Data contained other explicit examples of suicide risk factors being unseen, again following a transfer from another institution.

'We had a woman die in prison about two years ago and it says in the PPO report that she'd been brought back into the prison because there were some behavioural issues in another prison, but when she was in the prison before something had happened that was triggering, she'd told the nurse that there was um… some family issue that was going on for her [at] that time that was triggering and she was found standing on a bucket with a ligature round her neck the day before she died. i.e. she was rehearsing or something? But – she said she was ok. So, although, all the things were there – these are the things, these are the circumstances, these are the triggers, but she said she was ok. And instead of taking notice of this bit [makes gesture to the left], *we took notice of this bit* [makes gesture to the right]. *And we need to find a way to resolve that thing, where we say – we're not listening to you, when you say you're fine, we're not listening because we know all these things are actually triggering for you and we think you are at risk of ending your own life through suicide.'*

Taylor (C, senior health and justice staff member)

In this data, the prisoner was not just articulating her suicidal ideation but was 'rehearsing', making an attempt that was interrupted or demonstrating her distress for another reason, but the prison was still unable to prevent her suicide the following day. For staff going at speed or keeping going after another distressing event (see 4a.iii), not engaging too deeply or asking too many questions can enable them to finish their shift. Prison healthcare staff can *see, but not see*, meaning moments of prevention are missed, at times with fatal consequences.

Long-serving staff highlighted the way resourcing and bureaucracy impinged on their ability to spend time with prisoners, to exercise their professional curiosity and intervene in suicidal trajectories. As explored in chapter 4 with prison self-harm, managerial time again trumped process time when working with suicidal prisoners.

'God, I'd like to cut down on some of the templates that we have to fill in, to be honest!! I'd like to spend less time asking questions, which are the same

thing over and over again, and more time actually having more of those professional curiosity type questions, just to really understand what's going on with people.'

Fin (A, former RGN, Head of Healthcare, Operations Manager)

There was a lack of time and opportunity in daily prison work to ask nuanced questions or to linger long enough to perceive meaningful answers, which could be the difference between life and death. Taylor noted:

'… they [prisoners] respond to the question but that isn't enough, it's not enough. We need to spend more time with people.'

Taylor (C, senior health and justice staff member)

This lack of time for professional curiosity is an example of how government decisions about prisons are 'inextricably linked to organisational culture', that 'provides the backdrop to the changing social and political landscape, which filters down to individual practice encounters' (Burton and Revell, 2018: 1510). The pressures, paucity of staff and pace highlighted in chapter 4, hinders the professional curiosity of healthcare staff and hinders their potential to prevent suicides.

5c.iv) Staff experience suicides as preventable

All three findings above – the presence of known risk factors (transfers), the insufficiency and poor implementation of ACCT, and the lack of professional curiosity are contributed to by systemic pressures, driven by punitive, cost-cutting prison policies. Whilst prisoner suicides happen 'at the intersection of systemic, organizational, and individual factors' (Tomczak *et al.,* 2023: 29), governmental factors have at times been obscured and have received less scholarly attention in favour of clinical, psychosocial quantitative analyses, e.g. Favril *et al.* (2020), Fazel *et al.* (2017) and Zhong *et al.* (2021). Ludlow *et al.* (2015), and Tomczak's work on prisoner suicide (2018, 2022, 2023) and Ismail's (2019a, 2019b, 2023) work on prison healthcare explicitly reference policy and austerity factors. Also relevant here are Liebling and colleagues' work on the impact of government policies on the quality of prison life. For example, a single site prison study over two years showed 'high rates of suicide and distress' could be reversed

by ‘major investments… [to] management and infrastructure’, improving ‘culture, safety and levels of care for women’ raising its Measuring the Quality of Prison Life (MQPL) scores and crucially demonstrating that ‘a plausible causal relationship exists between improved moral climates and outcomes’ (Auty and Liebling, 2024: 731). Suicide scholars from non-prison settings note a ‘complexity and multiplicity of factors that may contribute to suicide’ which ‘can occur simultaneously alongside invoking government culpability’ (Mills, 2018: 315). Suicides named as induced self-violence in offshore immigration detention were cited as a ‘consequence of systemic pressures produced by the actions of powerful decision-makers’ within a ‘degraded psycho-social environment’ (Aitchison, 2024: 905). This thesis agrees: the framing from Mills’ (2018) work on austerity-driven welfare reform connected suicides quoted above, applies for prisoner suicides, an argument supported by Auty and Liebling’s (2024) findings. The potentially preventable deaths by suicide cited in this chapter, extend Aitchison’s (2024) findings to prison settings. Given the constraints to suicide prevention caused by governmental factors outlined earlier in this chapter, many prison suicides could be named as induced self-violence. The comparisons from child protection scholarship highlight patterns across a wider set of public services with squeezed staff, working at an unsustainable pace resulting in poorer, and at times deathly, outcomes for those they work with. Staff framed most prisoner suicides as preventable, even if they felt they personally did not have the power to prevent them, creating further anguish and despair in staff. The struggle to convene ACCT processes, with no time to be curious are the practical outworkings that constrained prison healthcare staff’s attempts to prevent suicide. These examples strengthen the argument that prisoner suicides are preventable and that many could be more suitably categorised as induced self-violence.

Conclusion

As with prisoner self-harm, the context and governmental factors influencing prison environments and resources were very present in data about staff experiences of prisoner suicides. Healthcare staff in prison worked with a wide range of suicides, attempted and completed. Staff described prisoner suicide as awful, experiencing grief and guilt in the aftermath. An original contribution to knowledge was that staff found more violence and viscera in suicide methods contributed to distress and was a potential indicator for trauma.

Suicide attempts could also result in enduring distress and salient memories. Staff reported keeping going within their shift following suicide for internal and external reasons, despite their strong emotional responses. *How* staff did this and the implications of that are explored further in the next chapter. Healthcare staff felt constrained in their work with prisoners, even after death, which limited their professionalism, dignity and autonomy, contributing to moral injury. Careless methods of informing staff of prisoner suicide diminished staff dignity and that of the prisoner. Staff considered many prison suicides were preventable. Where known risk factors were present, staff described additional distress, despair and futility following suicides. The pressures, paucity and pace of prison healthcare work, contributed to by governmental factors shaping prison culture, constrained staff's ability to undertake ACCT processes and stymied their professional curiosity. Studies from other parts of the public sector were illuminating here, demonstrating withering public services unable to give support to relational ways of working, which significantly contributed to deaths. This chapter demonstrated the experiences of those working in prison healthcare with suicidal prisoners was profoundly influenced by the underfunding and under resourcing of prison healthcare. Systemic and governmental factors have practical, and in some cases fatal, consequences for healthcare staff working with suicidal prisoners.

Chapter 6: Acclimatising to dehumanisation?

Please note: this chapter contains detailed descriptions of prisoner suicide and self-harm that readers may find distressing.

Introduction

Staff acclimatise to working with prisoner self-harm and suicide, and this acclimatisation is conceptualised here on a continuum. Findings in this thesis chapter extend extant scholarship on staff normalising, detaching from and becoming desensitised to working with prisoner suicide and self-harm, with novel findings on staff dehumanisation. It answers subquestions b) and c) of the research questions, regarding the enduring and cumulative impacts on staff of this work. The chapter also answers the second half of subquestion c), considering the consequences of cumulative impacts for staff responses to further occurrences of prisoner self-harm and suicide attempts. Without condoning the current conditions in prisons, this thesis proposes that acclimatisation to prisons and to prison healthcare work is necessary for those who wish to work in these settings over a number of years, to enable staff to function in such a specific and demanding environment. This acclimatisation is conceived as a continuum – from strategies that retain the human-ness of staff at one end, through phenomena more prevalent in the data of normalisation, detachment, desensitisation and dehumanisation. This chapter is focused on these more prevalent phenomena, with definitions provided in the relevant section. Dehumanisation of staff is not inevitable though systemic pressures make dehumanisation more likely, therefore, the title of the chapter ends with a question mark. The question mark used is also indicative of the processual ontological lens of this thesis, that avoids 'determinist dystopias' that criminological scholarship can engender (Tomczak, 2022a: 497). It instead embraces movement and becoming, emergent personhood (Liebling, 2019), thereby acknowledging people and places can and do change. Indeed, conceptualising acclimatisation as a continuum allows processes of change and responsiveness to environments over time which are dynamic and may further modify over time, in ways that existing typologies of staff adaptation (e.g. Cohen and Taylor, 1972; Crewe, 2009) implicitly do not. Therefore, graduated shading is used on the arrow below and phases are not attributed to fixed points.

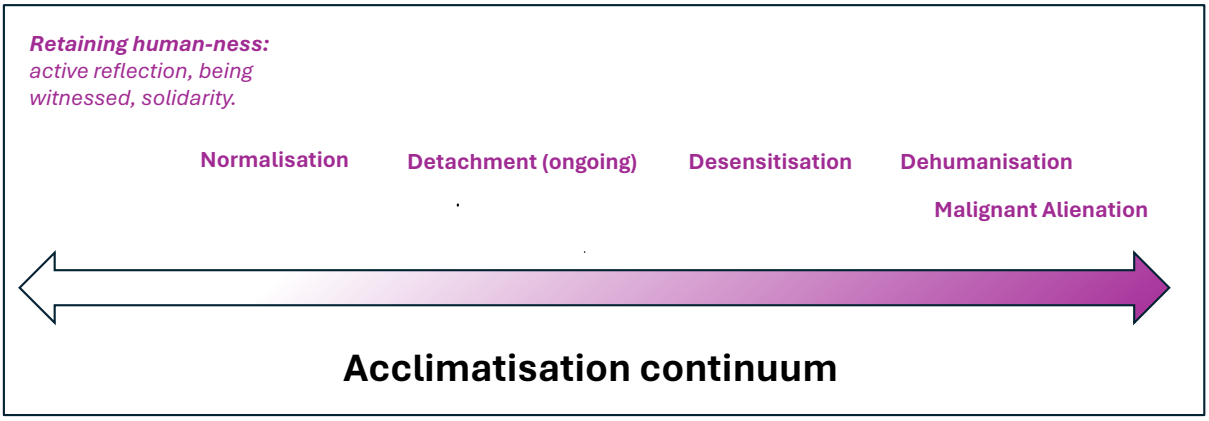

Figure 1

This thesis extends theories that prison staff, like prisoners, adapt, reconceptualising this as acclimatisation. It argues that given the pressure, paucity and pace encountered by prison healthcare staff in their prison work (see chapter 4), some staff modes of acclimatisation are more accessible. These more available modes are potentially damaging to staff, prisoners in their care and the prison ecology. Much has been previously written on prisoner adaptation (Clemmer, 1940; Cohen and Taylor, 1972; Crewe, 2009; Sykes, 1958). Some prison adaptations are more available to prisoners and indeed more *likely* than others (Kruttschnitt and Gartner, 2005; Crewe, 2009). Prison staff make adaptations too (Arnold, 2012; Crawley 2004a), undergoing a 'process of socialization', developing 'engrained habits in the course of their correctional experiences' (McKendy et al., 2021: 4). As explored in previous sections, prisons are a 'challenging and often dangerous work environment' (Ellison and Caudill, 2020: 1). New officers describe a 'process of adjustment or adaptation to prison life' to cope and continue in work, learning to detach from and conceal their feelings to this end (Arnold, 2012: 392). Crawley names this process acculturation: from *becoming* to *being* a prison officer (Crawley, 2004a). This thesis' ontological perspective counters that staff are always and still *becoming* and therefore, there is greater potential for change. A study of healthcare workers found most have to 'acclimatise to their poor working conditions' when they begin working in prisons (Ismail, 2023: 93). Staff acclimatise to the institutional environment and in the current conditions in prisons, many of the healthier modes of acclimatisation, e.g. clinical supervision, working as part of a consistent team, are less accessible to those who work there. The easy availability of self-harm-as-normal narrative for prison healthcare staff can lead to

acclimatising to self-harm as normal then morphing into potential desensitisation. This chapter considers the continuum of prison healthcare staff acclimatisation to suicide and self-harm and the implications of that for those in their care.

6a) Acclimatisation: the accessibility and ease of normalisation

6a.i) Acclimatisation: adjusting to prison healthcare

This study found prison healthcare staff went through processes of *acclimatisation*. It is originally a biological term meaning a 'process of gradual… adjustment… so that the stress of a new climatic environment is ultimately less severe' on persons (de Freitas and Grigorieva, 2015: 14975). In this prison thesis context, the word acclimatise was used by Riley and has been developed from this because inherent in the concept is change *as a response* to enable functioning in (new) environments and therefore is preferred over other synonyms e.g., adapt or adjust. As noted in the previous two chapters, context and conditions shape staff experiences, this chapter now considers how context and conditions shape staff attitudes, practices and behaviours through their acclimatisation. Staff in this study became acclimatised to the frequency and nature of prisoner self-harm, and for some, to prisoners' suicide. Staff also acclimatised to working with prisoner suicide and self-harm within the pressure, paucity and pace of prisons, with wider implications for the prison and its culture. Acclimatisation was chiefly achieved by the coping strategies of normalisation and detachment: from both prisoner self-harm and staff's responses to it. These coping strategies then could result in momentary or embedded and ongoing desensitisation to themselves and others. Participants viewed normalising self-harm as key to enabling functionality in the prison, however experiences of suicide(s) were not normalised in the same way, with most staff reporting sadness and/or grief. Acclimatisation coping strategies of normalisation and detachment with consequential desensitisation, are viewed as unfixed and dynamic, understanding change and movement may happen multiple times within a single day based on other contingencies. Due to interviewing *former* frontline healthcare staff, some were also able to talk about re-acclimatising after they left their prison healthcare role, their changed perspective and their retrospective sadness at how normal self-harm and suicide(s) had become whilst working in prison, bringing further novelty to this thesis.

Participants in this study demonstrated acclimatisation explicitly, e.g. the narration of and reflection on early prison work experiences, and implicitly, e.g. use of language and displays of emotion (or lack thereof). It enabled them to keep working in an environment characterised by high levels of self-harm, and in some cases, suicide and other 'potentially psychologically traumatic events', e.g. riots and assaults (McKendy *et al.,* 2021: 1). This had consequences for their attitudes and practices. Staff coping or defence mechanisms can manifest in negative attitudes and labelling self-harm as "non-genuine" or manipulative (Liebling, 1992; Short *et al.,* 2009), or as staff antipathy, which led to poorer outcomes for those who self-harmed (Dickson *et al.,* 2009). Staff responding to repetitive self-harm can develop a 'tolerance' to it (Marzano *et al.,* 2013: 8). Staff in this study reflected that their response to self-harm and suicide attempts was different from when they first began prison work and that they had since acclimatised.

Participant: *'… he was losing a lot of blood, but he was continually pulling out his arteries and his veins from outside his arm and nurses and the officers were absolutely covered in his blood, there was blood <u>everywhere</u> […] these are things that… not everybody sees everyday, so it is quite challenging'.*

Interviewer: *'Do you have a sense of why that one in particular has stayed with you?'*

Participant: *'Um, probably because it was one of my first major incidents.'*

Casey (A, former head of healthcare)

Another management participant noted the response and subsequent support needs of newer staff are different.

> *'I've certainly seen some people quite new to prison health who've seen some very serious cutting. There's lots of tissue damage, and they've been quite traumatised by that and they've needed some fairly immediate support.'*
>
> Drew (C, former prison doctor; national manager, prison health)

Over time, staff amended their expectations of their roles so that they could continue to work with regular self-harm.

> *'These are the things that you come to expect. You come to expect to see kind of awful assaults and people, um, you know tipping sugar water on themselves […] And you go in, you're a nurse, you have a clinic and you're suturing, but not post op […] or community ailments: I'm suturing people that have done it to themselves. So, it does become... very... yes, yes, something that you acclimatise to. […] when we talk about the impact of it […], I think that's why I draw upon my first jail. My experiences in my first jail, because that is when I felt that shock. That is when I felt that trauma and that confusion and the fear and the need to know more. Whereas, you know, it's never easy, but when you're a prison nurse, that's what your role becomes.'* [sugar water is a mixture of boiling water and sugar, can be used to intensify burns]
>
> Riley (former RGN and senior healthcare manager)

Trauma and fear were created in those initial experiences of prisoner self-harm, as well as sparking a professional curiosity. Staff acclimatised by shifting their expectations and reframing what their role entailed. Workers may still experience the work as challenging and at times traumatic, but with less acuity than originally experienced. Like workers in French prison settings (Boudoukha *et al.,* 2013), prison healthcare staff used a variety of emotional blunting and numbing techniques to normalise and detach from the difficult emotions created in response to this work. Acclimatisation then covers a dynamic continuum of cumulative prison healthcare staff responses, adapting and changing their attitudes, practices and behaviours so they can continue to work in prisons with high levels of prisoner suicide and self-harm. The next sections explore normalisation and detachment as strategies for working with high levels of self-harm.

6a.ii) Normalisation: an accessible coping strategy

Staff frequently cited normalisation as part of their acclimatisation. Staff normalised self-harm to help them manage their expectation of and response to it. Participants did not frequently normalise the occurrence of suicide, unless their profession involved regular expected encounters with suicide e.g. as a psychiatrist. The process of prisoner self-harm becoming normalised appeared frequently in the data as part of staff's acclimatisation. Staff normalised self-harm to help them manage their expectation of and response to it. Foucault wrote and spoke about the process of normalisation, briefly explored here to aid illumination of how this process is germane to this study. Once a norm is established, it reproduces itself (and other norms) in a process of normalisation to the extent that those processes become invisible, establishing the norm as 'natural, necessary and normal' (Taylor: 2009: 46). Normalisation then 'consists in trying to get people, movements and actions, to conform… the normal being precisely that which can conform to this norm' (Foucault, 2007: 85). Normalisation has an 'exacting and coercive role' (Foucault, 2003: 50). As such, it is a process that 'often takes place unnoticed' and is difficult to reverse once 'normalizing norms' are established (Krzyżanowski, 2020: 435, 437 respectively). Prisoner self-harm creates a paradox in being simultaneously regarded as abnormal, e.g. outside the norm and other, whilst also being subject to normalisation, e.g. becoming reified as a social norm (Foucault, 1980). Staff in this study noted that the prevalence of self-harm created limitations of 'thought and existence', which then limited their capability in conceptualising alternatives and taking alternative actions (Taylor, 2014: 6). Normalisation then is defined here as a process that can obscure the reification of norms, which means the normalised phenomena [e.g. prison self-harm and suicidality] becomes viewed as inevitable thereby curtailing the [staff] ability to conceptualise alternative actions.

Staff in this study minimised and normalised the occurrence of prisoner self-harm. To do so their emotions were 'minimised, normalised and controlled to a significant extent' (Arnold, 2017: 292), which enabled them to do their job and/or reduced feelings of stress.

> *'But it's stressful when you see, when you hear about people harming themselves and not wanting to be alive, that's stressful, of course, it's gonna have an impact on how you feel and I think you kind of get used to it, […] possibly, which is not a healthy thing, you get a bit numb to it*

sometimes. But it becomes such a normal part of your day…'
Frankie (A, former prison psychologist)

Other participants cited dark humour and "forgetting" about incidents. When asked about the impacts of this work, this participant replied:

'Um. We spoke about it, we joked about it. We forgot about it. We just took it as being all part and parcel. It's part of the job. That sounds really hard and really callous and really quite nasty to say, but. You're treating an injury first, and a person second.'
Charlie (A, former RMH)

The idea that the injury can be treated as separate to the person, moreover that the injury – and not *the person* – should come first, suggests detachment also being deployed as a coping strategy. It diminishes the humanity of the person being treated and means the worker here protects themselves from engagement with another person by instead tending to the physical injury. Previous scholarship shows staff deeming prisoner self-harm as 'part of the job' enabled staff to cope (Walker *et al.,* 2017: 816). This study extends this finding: healthcare staff in this study, whose work included at least 48 prisons, considered self-harm a *normal* part of the job. The expectation that self-harm is a normal part of prison work, then has institutional and individual implications for those trying to reduce it.

It was hard for staff to maintain the belief that prisoner self-harm was not inevitable and not normal. This influenced their treatment of prisoners who self-harmed before, during and after the occurrence of self-harm. This senior practitioner noted the challenge:

'It's something that you hear […] it's part of - which I think is dreadful – is it's part of the day job. And I think one of the challenges, is how do you not normalise that? And how to not become blasé about it? Because... it is shocking and it shouldn't happen, but it's when you're working in that kind of environment and other staff potentially are saying just like - ohh yeah, it's just what happens – it becomes very different.'

Hilary (B, senior national role, health and justice)

Another senior participant highlighted colleagues normalising and categorising self-harm to decide how to respond, minimising some occurrences. This also demonstrated how an attitude or belief about self-harm then influenced their professional practice.

'You could see then when staff, then are sort of thinking, well, "how, how serious is this self-harm? So, this is just a minor self-harm, since the major self-harm like this needs a different response to that one." When - it's still self-harm.'

Alex (B, senior prison health expert and prison doctor)

Categorisation helped overloaded staff cope with self-harm and further normalised it.

The normalisation of self-harm constrained alternative ways of staff viewing and working with prisoners who self-harmed: alternatives to self-harm and suicidality, to hardened prison cultures and alternatives that enabled responses other than normalising. Staff in this study lacked pathways and means to address root causes of self-harm, instead choosing options from a superficial, insufficient palette influenced by the availability of normalisation.

'I think the thing that troubles me about self-harm is it's, it's almost an expected normal [...] it's a pattern of behaviour that is so normalised, that I think staff become quite desensitised, so desensitised to it. Because it's almost like there's not much you can do about it other than open an ACCT or put somebody in a health care unit if you have one, or you asked the doctor to prescribe a medication.'

Alex (B, senior prison health expert and prison doctor)

Staff worked with a sense of futility and a lack of options, which reinforced the accessibility of normalisation as a coping strategy. This participant reflected on the consequences of that:

'I think it [self-harm] became massively normalised and in prison, there

became the attitude that like - what do they want? Why are they doing it? And this is why I think I'm finding it quite hard to like - OK, what kind of like real structures and plans did we put in place to like psychologically discuss self-injury? Or send someone to a psychologist? Because it wasn't perceived that way. It was perceived as what needs can we meet […] for you to stop you doing this? Like, you're not going to get single cell, like there's no point cutting up, you're not going to get tobacco, there's no point cutting up. So, I think I approached self-injury really in that.... I kind of like became a bit institutionalised in that way, and approached it in a – how can I make your life more comfortable in this horrible place, so that isn't your go to coping strategy?'

Sullivan (A, former frontline VCS healthcare worker)

Normalisation can lead staff to view self-harm as instrumental and manipulative. Self-harm that is perceived by staff as manipulative is a common finding in other prison studies (Liebling, 1992; Kenning *et al.,* 2010; Marzano, 2007; Smith *et al.,* 2019). This view of prisoner self-harm is linked by participant Sullivan to being institutionalised and becoming acclimatised to the expectation of self-harm. There was no capability to consider 'real structures and plans' (Sullivan) that might enable different outcomes for those self-harming. Prison healthcare staff's creativity and curiosity were constrained by expected, inevitable prisoner self-harm and suicidality, demonstrating the consequences of normalisation.

Staff had a temporal or practical interval between their experiences and the data collection, which rendered what had become invisiblised as normal whilst they worked in prisons - high levels of prisoner self-harm - as visible again. This interval enabled rich data as staff recalled perceptions, feelings and responses both *at the time* and how they viewed them *now*, creating nuanced, thick descriptions and reinforcing the dynamic, contingent nature of knowledge. This former frontline worker reflected:

'… it's quite strange kind of thinking back to like what was so normal and you were in it every single day […] yeah, people cut themselves every day. And hearing myself say those things feels very uncomfortable now and it

makes me feel very uncomfortable, like why was that so normalised? But then it's normalised cause you had to go to work every day and get on with it I suppose… And so yeah, just hearing myself speak like that feels quite sad really, that's what prisons are like.'

Sullivan (A, former frontline VCS healthcare worker)

This data articulates the cyclical way Foucauldian norms work. Normalisation had minimised self-harm as usual and invisiblised staff's responses to it; reflecting back on those experiences enabled the illumination of unease, discomfort and sadness about self-harm and the normalisation of self-harm. Data suggested that enabling serving staff to reflect on their work with self-harm and creating distance or another perspective, may help reduce the phenomena of normalisation and make other adaptations, or acclimations available to a wider group of staff. Finding ways to do this, e.g. clinical supervision, that were realistic and accessible to serving staff could engender positive outcomes.

Normalisation had consequences: staff working with prisoner self-harm may become too casual or 'blasé' (Hilary), with repeated exposure can mean 'you get a bit numb to it sometimes' (Frankie) and may dehumanise the prisoner 'treating an injury first and a person second' (Charlie). Practitioners are and were working in broken institutions with a lack of accessible mental health care and inadequate tools to reduce self-harm and/or tackle the deeper causes. The mental gymnastics required when working in the damaging institution of prison, produce the coping strategy of normalising self-harm which then diminishes the hope of recovery, the idea that things could be different, making it harder for staff to hold that possibility in mind and influencing the care provided. Normalisation was a coping strategy to navigate a damaging prison environment. The other key coping strategy staff deployed was detachment. Detachment will now be considered before exploring the further consequences for practice of these coping strategies.

6b) Acclimatisation: detachment

This thesis creates novel conceptions of detachment as temporary, chronic and/or acute. Alongside normalisation, participants used detachment as another tool to manage working with prisoner self-harm and suicide(s). Staff narrated degrees of detachment, from intentional professional detachment - temporary, through to more enduring emotional detachment – chronic, resulting in desensitisation. Both medical and prison literature recognise staff use of detachment in these fields. Menzies-Lyth's (1988) foundational nursing text cites detachment and denial of feelings as strategies to manage anxiety and retain clinical functionality. Officers, '… like nurses, are expected to remain emotionally detached' (Crawley, 2004b: 420), particularly as emotional detachment is perceived to be associated with role competence (Barry, 2020). Detachment can be self-protection when working with self-harm (DeHart *et al.,* 2009; Smith *et al.,* 2019). Prison officer studies employ Hochschild's theories of emotional labour (Barry 2020; Crawley 2004a; Nylander, 2011; Slade and Lopresti, 2013), with particular attention given to surface acting. That is performing emotions to align with institutional feeling rules whilst suppressing other emotions, creating emotional dissonance (Hochschild, 1983). However, detachment carries risks. Officer studies noted surface acting and emotional dissonance created an 'under- stimulated emotional exchange where "the other" is objectified', which then enabled 'cynicism and detachment' (Nylander, 2011: 479). Similarly, where detachment became embedded it reduced staff care, meaning they responded 'to clients in negative, callous, and dehumanised ways' (Maslach *et al.*, 2001: 400). This study differentiates detachment that is temporary, chronic and/or acute, to enable a deeper understanding of detachment and its utility in demanding workplaces. Prison healthcare staff were cognisant of the potential pitfalls of detachment as a coping strategy, but as with normalisation, considered detachment a least worst option in a setting with limited available coping strategies. Having employed detachment, participants nevertheless hoped to stave off chronic desensitisation. They hoped to retain their compassion and professional competence whilst working with suicidal and self-harming prisoners and not become chronically detached, to the detriment of their practice.

6b.i) Temporary detachment: aiding good practice?

This study extends extant work by conceptualising detachment as part of acclimatisation continuum and by differentiating different genres of detachment. This section considers *temporary* detachment. Detachment from one's own emotions and responses can enable

workers to maintain professionalism in their interactions, e.g., when responding to prisoner self-harm. As a junior doctor in a mainstream context noted, '… we may exercise "clinical detachment", a conscious choice to numb ourselves to emotional resonance with our patients in order to maintain scientific objectivity, and to help us cope, to carry on for the benefit of the next patient in line' (Austen, 2016: 376). Studies in wider emergency responder contexts demonstrated the value of professional detachment in first responders subsequently "coping well" (Davies *et al.,* 2008: 204) and in preventing PTSD in ambulance staff (Behnke *et al*., 2019). However, other studies attest to persisting emotional detachment creating 'adverse consequences insofar as it becomes one's default mental state beyond the crisis' (McKendy et al., 2021: 4) and difficulties in the home lives of prison staff (Crawley, 2004a). In this study, staff cited use of detachment. A handful of staff were able to deploy emotional detachment as a *temporary* strategy whilst at work due to management support and/or supervision. This prevented detachment becoming chronic and therefore problematic.

Staff regulated their detachment through interaction with colleagues or supervisory environments that facilitated their ability to access a wider range of feelings and responses to their work. However, this was rare. It depended on the time and space to facilitate strong working relationships and also, to adhere to clinical supervision requirements, where they existed. Practitioners able to discuss temporary detachment and also the accompanying often unnamed emotions they were detaching from, were those working in mental health in various roles, e.g. psychiatrist, psychotherapist. Arguably, these roles are more practiced in reflecting on and articulating difficult and complex emotions. This psychiatrist explained:

> *'I think as […] a human being, it's very easy to allow your personal feeling to cloud your judgement. I think it's really, really important that however you feel, you don't respond how you feel. […] I mean obviously some patients are triggering to staff and they do annoy staff, we're all human, fine. But I think the important thing is to recognise that that's happening for you personally and that shouldn't change how you are professionally […] There's nothing wrong with having those thoughts - you might be frustrated. You might be annoyed, but you still have to go through the usual process. So, there's an aspect of self-protection there, I think that because you're... at that time*

when you're a bit worn down or whatever, or […] you're fed up with the patient or whatever it might be that you're feeling, is to not pay attention [to that] but you need to have the discipline to maintain the same… sort of focus. That's important at those times... Probably more important at those times.'

Jean (A, former prison psychiatrist)

There is a frankness here about feelings such as annoyance and frustration that maybe present in this work. Temporary detachment enables those feelings to be distanced from the practitioner's interactions, to focus on the patient, reducing the influence of those feelings on professional judgement and care. There is then a re-attachment, an acknowledgement and ownership of those feelings away from the frontline setting and the prisoner.

Officers and other healthcare staff may be less accustomed to acknowledging, connecting with and reflecting on these difficult feelings, reducing the availability of detachment as a temporary phenomena. This finding provides empirical evidence for Austen's hypothesis: that the use of supervision, Schwartz rounds [structured, reflective groups for healthcare staff], peer support and reflective practice can interrupt the journey from temporary detachment to generalised emotional detachment, thus avoiding healthcare staff burnout (Austen, 2016). The consequences of prison work environments with healthcare staff working at pace is a dearth of these interventions, meaning increased likelihood of generalised detachment, staff burnout and therefore, poorer outcomes for prisoners. Staff that could detach from their emotional response *temporarily* were better enabled to care for prisoners who self-harmed and were suicidal; providing there were opportunities to reflect on and reconnect with their emotions away from the frontline.

6b.ii) Chronic detachment

More commonly, data demonstrated the experience of ongoing *chronic* detachment from a range of responses and emotions. Previous studies found emotional detachment was 'a practical necessity' when working with prisoner self-harm (Marzano *et al.,* 2013: 9). Parallel work by Liu *et al.* (2022) with another group of "stigmatised patients", people who inject drugs (PWID), examined the responses of medical trainees, noting their physical and emotional

distancing from patients. Trainees stated this distancing protected against burnout and enabled 'adequate care for future PWID patients that they would inevitably encounter' (Liu *et al.,* 2022: 1012). Employing ongoing or chronic detachment to enable functionality and service to future patients is not supported by the evidence, which suggests that chronic detachment risks *reducing* efficacy with future patients (Marzano *et al.,* 2013). Earlier studies of officer staff noted private prisons were characterised by "light" regimes with "absent" although physically present staff, with negative implications for prisoner safety; prophesying that as public sector prisons staffing models were restructured to resemble private prisons, 'absence' would feature more across the prison estate (Crewe *et al.,* 2014: 406). Prison healthcare staff in this study were working in the context of increasing light-absent officer cultures caused by restructuring and therefore less staff and less experienced staff. Exposure to prison suicide and self-harm in these "absent" contexts, accelerates the likelihood of temporary detachment to become chronic. Staff in this study acknowledged that chronic detachment neither served them nor the prisoners they worked with. It was a pragmatic coping strategy in a workplace with a lack of or limited clinical supervision, with staff relationships weakened due to use of agency staff, high demands or low staffing numbers meaning staff struggled to detach temporarily then reconnect to wider emotions. This participant summarised this core finding:

> *'… people become efficient at dealing with it, but as they become physically efficient, they become more psychologically detached, I think largely.'*
> Lee (B, senior prison health expert and prison doctor)

Professional competence and practical skill with those who are suicidal and self-harming may increase with exposure and over time; however, as these skills evolve, the emotional self is subdued and repressed. Other participants noted the problematic nature of chronic detachment:

> *'I definitely saw some of my colleagues verging more on the side of, what I mentioned before, of disconnecting a bit from it to try and protect themselves from the difficult things that they were seeing. But for some colleagues, perhaps slightly more on the end of being a bit <u>too</u> disconnected and then struggling a bit to connect with the support they needed to give to the women.*

And just being quite, that being exacerbated by being just very burnt out I think from understaffing and under, being under resourced in general. And so, I think viewing self-harm for some colleagues was quite difficult and I think they struggled to cope.'

Sammy (A, former prison psychologist)

Staff were unable to connect with their own emotional world and that of the prisoners they worked with. In prison healthcare staff working under pressure, with a paucity of resources and at pace, detachment can easily slide along the acclimatisation continuum desensitisation and beyond, leaving staff unable to do their work effectively. This heightens the likelihood of negative outcomes for the prisoners they work with, as well as for staff's own professional and personal lives.

6b.iii) Acute detachment

Frontline staff also described an *acute* form of detachment accessed during experiences of prisoner suicide and self-harm that could be categorised as critical incidents. A critical incident is 'a powerful and overwhelming event that lies outside the range of usual human experience' that threatens to overwhelm usual coping strategies (Antai-Otong, 2001: 127). The ability to acutely detach helped nurses take 'a task-focused approach to patient care' whilst 'temporarily suspending higher thinking' and to compartmentalise 'negative thoughts and emotions derived from the critical incident' (Harvey and Tapp, 2020: 5). Acute detachment serves a useful, time-limited purpose in emergency responses. Participants in this study narrated accessing acute detachment, becoming focused on the practical tasks of incident management. Casey explained:

'You just flip into that incident management mode and deal with it. I feel that if there was anything significant happening I'm quite able to, in my head compute and understand easier and take out that emotion – which isn't always a good thing.'

Casey (A, former head of healthcare)

The use of machine-based language here - 'compute' – reemphasises detachment from emotion, which the participant acknowledges may not be helpful. Another participant explained their process when approaching an incident:

> *'… if I ever went to anything that I knew was going to be traumatic […], any Time the call came on the radio that I would go or I'd want to go and support my staff with, that little self-talk on the way. But it wasn't a kind of self-talk, it was a kind of shutting down. And kind of back to autopilot and one of the main things that I always thought was important for me to do is get to the scene, take control […] I know the kind of panic and I know the fear that people are feeling so, if I can go in and just take control, make sure that people take a breather and just assess what's going on, or not feel pressured to be the one to jump in... then it helps them process it, and, um maybe I'm teaching them in the future.'*
>
> Riley (A, former RGN and senior healthcare manager)

Riley distanced themself from emotions, from panic and fear, historicising them whilst noting *other* people feel these emotions in the present. Closing their emotions off meant they felt they could calmly take control, reassure and aid good decisions. This motivation aligns with those expressed in temporary detachment. Accessing acute detachment was also motivated by a desire to protect colleagues and demonstrate a way to reflect before acting, even in a crisis. Prison healthcare staff were adept at accessing acute detachment in a crisis.

Data also included highlighted a detrimental aspect of acute detachment: it can become habitual and damage delivery of healthcare to prisoners. Divergent from many other emergency responder roles, prison healthcare staff can work with the same prisoner for days, weeks, months or even years. Many police, firefighters or paramedics may be adept at acute detachment, but they may never meet the recipient of their care in a conscious state. Acute detachment in prison healthcare staff may linger into future interactions with prisoners, beyond crises and critical incidents. Riley continued with this sober reflection,

> *'But […] maybe it's not teaching them in a healthy way, because that's my*

response to seeing everything beforehand, is just kind of shutting down and then just… getting through it.'

Riley (A, former RGN and senior healthcare manager)

Staff linked their previous exposure to prisoner suicide and self-harm with their need to shut down prior to engaging with new incidents, restraining their emotional response. This senior participant identified the self-protective role of acute detachment:

'And sometimes in efforts to protect yourself from that sort of trauma as a caregiver, you may find yourself emotionally, emotionally shutting down or making yourself less available, in a way that can start to impact on your professional duty of care.'

Kerry (B, former prison doctor; senior national role, health and justice)

This supports findings from a study of intensive care nurses who used 'autopilot' to limit their emotions. This then could 'compromise the human connection and expert practice that are necessary in the care of the critically ill' (Harvey and Tapp, 2020: 6). Staff may use detachment as a protection mechanism, to prevent future significant negative impacts, as well as using it as a coping mechanism for things already experienced. The use of acute detachment can lead to poorer engagement with and care for those who are suicidal and self-harming, exacerbating their stigmatisation and worsening outcomes. Both chronic and acute detachment may diminish rapport, compassion and delivery of healthcare. The further implications of acute and chronic detachment are explored in the next section on desensitisation.

6c) Desensitisation

Staff desensitisation is conceptualised here as part of a continuum of acclimatisation. Desensitisation has consequences for practice: staff that are less responsive, complacent and with examples of malignant alienation. Chronic and/or acute detachment and/or constant normalisation led to staff becoming desensitised, which Hoffman describes as 'indifferent to suffering' (Hoffman, 2000: 203). Prison cultures that view prisoners as experienced objects,

rather than emerging, experiencing subjects (Liebling, 2019), e.g. those in which prisoners are objectified, may encourage reductive staff narratives about prisoner suicide and self-harm, further contributing to desensitisation. Desensitisation in this context is defined as: a consequence of exposure *over time* contributing to an emotional hardening and a resultant lack of care for or interest in prisoners. Desensitisation has implications for healthcare staff practice. Becoming desensitised when working with people who self-harm is reported across settings, e.g. staff in forensic settings became habituated and desensitised to self-harm as a protective strategy (O'Hara *et al.,* 2021). Prison studies show desensitisation as a strategy for 'coping "in" the prison', enabling calm at incident sites and inevitable 'due to the frequency of exposure to repetitive self-harm incidents, and the range of severities and methods witnessed' (Walker et al., 2017: 816, 817). Desensitisation is named as a key facet of correctional worker carceral habitus in McKendy *et al.*'s 2021 study, extending Caputo-Levine's (2013) work on prisoner carceral habitus. The other key facets being hypervigilance, disillusionment and distrust, which combined with desensitisation, may enable workers to function but can be deleterious for their work and wellbeing (see also Arnold, 2012). Findings from this study build on Arnold (2012; 2017), McKendy *et al.* (2021) and Walker *et al.*'s (2017) work highlighting staff desensitisation when working with self-harm, identifying further consequences for healthcare staff practice and poorer outcomes for those in their care. The first section explores staff desensitisation and the effects on them, with section 6c.ii and 6c.iii considering how staff desensitisation impacts the prison and prisoners in their care.

6c.i) Desensitisation: a consequence of chronic coping

Prison healthcare staff could become desensitised over time when working with self-harm. Staff's use of normalisation and detachment over sustained periods of time to cope led to being desensitised to prisoner self-harm and suicidality. As one participant noted:

> '*… you are dealing with your trauma by maybe being less sensitive to that of others.'*
>
> Kerry (B, former prison doctor; senior national role, health and justice)

Desensitisation in this study was reported as a less dynamic phenomena than either normalisation or detachment, requiring major intervention to address and alleviate it, e.g. a

long period of time away from work. However, becoming desensitised is a process, meaning there are multiple possibilities for the process to be interrupted. Participants noted the cumulative nature of desensitisation, a consequence of "coping" over time. Drew commented:

> *'Staff who've worked a long time in prison... it's normalised for them, so they're chronically traumatised. And you almost have no reaction. We've heard about incidents […] something that's actually awful when you think about it, and the new nurse has been like a rabbit in headlights, and the experienced nurse has said - well, this happens all the time, just get on with it. And... I think* ***that's,*** *that's perhaps evidence of burnout and compassion fatigue due to that, chronic... the chronicity of that trauma [..] there's a "just get on with it", and when you say, "are you OK?" afterwards, they say "I'm fine" and get on with the next one. For any normal healthcare professional would, would just not happen....'*
>
> Drew (C, former prison doctor; national manager, prison health)

The comparison with a newer staff member demonstrates the acclimatisation and the normalisation utilised by the more experienced staff member. Drew talks of 'chronicity' to describe staff's trauma, highlighting the role of cumulative exposure in creating trauma. The expectation of working at a fast pace is present again, as staff move from one traumatic incident of self-harm to the next, without time to reflect or to recover. As with detachment, being desensitised affected staff's awareness of their *own* emotional world, not just those they worked with. Desensitisation can leave practitioners unable to notice or attend to themselves, as Casey described:

> *'It's easy to forget that we're all humans sometimes, especially when we're so just focused on getting work done and you know, we become robots. I think it's easy to forget that we are human and things happen in life.'*
>
> Casey (A, former head of healthcare)

Task-oriented, robotic practitioners continued delivering healthcare to those who self-harm, thus potentially exacerbating the harm to both practitioner and the prisoner. There is an 'absence' noted in the data hereIn these fast-paced prison environments desensitisation to prisoner self-harm and suicidality is not inevitable but may *feel* inevitable as cumulative experiences erode any experiences of alternatives.

There was a small amount of data that demonstrated the presence of desensitisation in participants - they more usually described the desensitisation they observed in others. These data were outliers but are included here for completeness and as an indication of how desensitisation manifests and impacts practice. Previous work has shown that working with high volumes or repeated self-harm incidents can contribute to staff desensitisation (Marzano *et al.,* 2013). This study agrees. For example, Casey noted:

> *'Always used to have repeat self-harmers. Somebody that used to pop a pen up their arm constantly, somebody that used to pull their arteries out constantly and so, yeah, all the time.'*
> Casey (A, former head of healthcare)

Casey presented these examples matter-of-factly in a casual vernacular, although depicting visceral incidents. There is no hint of their messiness or their potential extra-ordinariness to a non-prison audience, although participants understood the interviewer held a partially insider research identity, which may have enabled this casual delivery. Incidents are normalised as an expected, regular occurrence in prison healthcare, demonstrating a degree of desensitisation to self-harm. Other examples were delivered with a similarly flat affect and matter-of-fact tone. Jude recalled:

> *'I remember one particular girl whose, whose arms were very... they'd gone very white. I don't know if you've seen that, you know, because they've cut so much, they've literally criss crosses and it's just white, it's white dead flesh. It looks like roast pork, I always thought.'*
> Jude (A, healthcare support worker)

Data here demonstrates the detachment, hardening and desensitisation that led to identifying another living human being's body as having 'white dead flesh'. The comparison to a foodstuff is also notable. Descriptions like this highlight where detachment has become desensitisation, with negative consequences for the prisoner. The following sections will now further consider how desensitised staff are compromised in their ability to care for suicidal and self-harming prisoners.

6c.ii) Desensitisation in practice: less responsive and complacent

Staff experiencing ongoing desensitisation then became less responsive and also, complacent in their work with prisoners who self-harmed and/or were suicidal. Officer studies demonstrate desensitisation can mean neglect of 'prisoners' psychological welfare', whereby staff 'fail to perform their job properly' (Arnold, 2017: 292). And as a consequence of exposure to prisoner suicide(s), officers can be 'numb to experiences which should trigger "corrective" responses' (Liebling *et al.*, 2012: 160), creating 'risks for future suicide prevention' (Ludlow e*t al.,* 2015: 57). Data in this study supports these extant findings; it extends them to prison healthcare staff and builds on them to identify diminished responsiveness and complacency as core implications for practice due to staff desensitisation. Working with high volumes or repeated self-harm incidents can contribute to desensitisation (Marzano *et al.,* 2013). Yet data from this study suggests that being less responsive is a particular risk when working with repeated self-harm. Alex reflected:

> *'I want to say something like a lack of compassion... Most people that work in prisons are compassionate people, yeah? But, when you've seen 20 or 30 or more episodes of self-harm, and the people around you have seen multiple episodes of self-harm, or give you the view that this person always does this particular behaviour, that that's expected, then it normalises something which is actually not particularly normal or appropriate […] then you end up in the desensitised position, where you're less likely to react or respond. And that, in a way, doesn't really improve the situation as we know, because we still have really significant levels of self-harm across the prison estate. Really at quite staggering levels […] So, it's around that sort of desensitisation, and not normalisation, of something that you're exposed to high prevalence of in*

the prison.'

Alex (B, senior prison health expert and prison doctor)

Self-harm became so normalised that staff became desensitised to it, blunting both the practitioners' emotional responses, their observational powers and therefore, clinical responses. This created a downward spiral: staff noticed less, therefore becoming less responsive, demonstrating desensitisation in practice, or as Chris termed it 'complacent' practice:

'I did a death in custody review where this lad had, um, killed himself and when I looked back, he had something like 18 days straight of self-harm. And there wasn't anything done about it. The way the alarm got rang blah blah blah, nurses went, patched him up, off you go. Next day alarm went off, nurses ran, patched him up - 18 days straight. Now he went on and he killed himself. But you look, and you think that's complacency. Because actually, they know he doesn't mean it, they know it's cause he hasn't got a vape or he wants a different prescription or it's "I want something" […] So, because it's based on that, that's where the complacency kicks in. Because you're not getting it, you're not getting your vape. You can self-harm all you like but you're not getting your vape, don't know why I'm using that. And then one day, you get a [knocks hands together]… And it's a 23 year old, who wants his mum.'

Chris (C, former nurse; senior health and justice manager)

Data here emphasises the sad reality of many prisons, where people who are sad and mad are far more numerous than the bad (Ramsbotham, 2003). Staff made assumptions about what drove the self-harm, i.e. the bad, rather than the sad. In this case the presumption that it was goal-oriented, to acquire something and not for other reasons, led to professional *complacency,* with fatal consequences. Instead, there could have been professional *curiosity* anytime during the 18 day period of the prisoner's self-harm, with alternative strategies to alleviate it explored and the potential avoidance of death. However, as previously explored in 5c.iii, governmental factors create prison pressures, paucity and pace, which constrains staff

opportunities for curiosity, resulting in complacency e.g. responding to the self-harm wound medically without holistic consideration of the scene. Findings from this study suggest, as with previous officer studies, that prison healthcare staff becoming desensitised from and to prisoner suicidality and self-harm, impacts on the (health)care they provide to prisoners. Desensitised staff become less responsive and less curious, whereby staff become complacent, sometimes resulting in further prisoner self-harm or death. Data in the next section considers how staff desensitisation does not only lead to omissions in care but can cause hostile treatment of prisoners.

6c.iii) Desensitisation in practice: malignant alienation

Another way that desensitisation affected practice was prison healthcare staff becoming malignantly alienated from the prisoners in their care. Data contained uncomfortable reports of bad practice in these cases. Malignant alienation describes a deterioration in relationship whereby professionals view their patients(prisoners) 'as difficult, provocative and manipulative', resulting in hostility towards the patient (Whittle, 1997: 5). When this view persists, it alienates the practitioner from the patient (Watts and Morgan, 1994). In its original conception, the consequence of malignant alienation between staff and psychiatric in-patients was patient suicide (Morgan and Priest, 1984). The term is now used more broadly to indicate poor patient outcomes, given that 'patients also experience alienation that has seriously detrimental associations (i.e. is malignant) but is not linked with suicide' (Whittle, 1997: 5). This study uses the wider conceptualisation of malignant alienation, e.g. resulting in detrimental patient(prisoner) outcomes, reflecting the usage by participants in this study. Although, the concept has been discussed in relation to prison healthcare in conference papers, e.g. Fiddler and Joliffe (2016), Walsh (2022). A study of secure setting nurses found those who responded with antipathy to self-harm and who spent long periods of time exposed to recurring self-harm, were *at risk of* malignant alienation (Patterson *et al.,* 2007). The role of being exposed to self-harm over time in desensitisation has already been highlighted in this study. Malignant alienation has four components: patient factors, staff factors, staff-patient interaction and the (hospital) environment (Watts and Morgan, 1994: 11). In this study traumatised, desensitised, fatigued staff (staff factors), working with high levels and/or repeated self-harm (patient(prisoner) factors), in under resourced prisons (environment

factors) led to a serious decline in staff-patient(prisoner) interactions, with potentially fatal consequences.

Retaining empathy and patience as a healthcare practitioner in prisons where self-harm is normalised, work is pressured, there's a paucity of resources and its fast paced, is challenging. The difficulty of delivering compassionate healthcare and not problematising or objectifying people in these circumstances, was noted by Lee:

> *'… it's them and us, the problem patient […] I've seen that on the ground brought in more acutely with stretched nursing staff, stretched officers, and there's been a, probably as a result of trauma for staff, but there's a lot of what we would regard as unprofessional talk, and it's about people who have maybe self-harmed, maybe repeatedly self-harmed, maybe are... on a dirty protest, maybe are jumping on a netting wanting, a vape or something like that... it's the behaviour that is challenging to observe, becomes the person who is. And the easiest way can become to separate that person from being someone you want to help. I've seen tired nurses I've seen those who, they are Hotel two, the emergency nurse, and they're called out for the tenth time that afternoon to see the same patient who's opened up the same wound.'*
> Lee (B, senior prison health expert and prison doctor)

Drained staff may conflate difficult behaviours with being a difficult person, making that person someone staff seek to be separate or alienated from. Lee cited a prisoner repeatedly self-harming to highlight where the risk of staff wanting to alienate is greatest. Other participants also noted that prisoners could become "the problem" to be avoided, rather than a patient to be provided with healthcare.

> *'This might come out wrong, but I, I guess it's just another thing that then adds to your workload, doesn't it? And we do, do it in nursing and it's not the right way to think, but, that patient that's repeatedly doing something that takes up your time, you start to, yeah, you start to lose that compassion, and it's almost they've become the problem. And I think that's a challenge*

of how do you not get that into that mindset?'

Hilary (B, senior national role, health and justice)

In such highly compromised custodial environments, the question of how staff resist inculcation into mindsets of normalising, problematising and then alienating prisoners who self-harm was painful and pertinent. It remains so. Participants spoke with frankness and self-awareness of how compromised their statements about their lived experiences were. Chapter 8: Pockets of Hope will explore how some prison staff avoided such mindsets, but the scale of the challenge should not be underestimated. Traumatised, stretched staff problematised prisoners, alienating staff from those in their care and, in the worst cases, created poor practice.

Data demonstrated that malignant alienation in prison healthcare staff was a process that occurred over time - a chronic, rather than acute, phenomena. A long data excerpt is used here to highlight the insidious process of malignant alienation. The first section explores the journey of traumatised staff becoming alienated from prisoners as a coping mechanism.

'I think it also comes from the way that patients approach us […] that their requests for help are often not done in a very traditional way, so you get the rudeness, you get the threats, you get shouted at a lot, together with that chronic trauma from all the self-harm. And, if you're cutting people down from a ligature and they've been hanging, that's a traumatic thing, but a lot of people who work in prisons have seen and dealt with that. And I think, possibly as a defence mechanism […] that leads to compassion fatigue and more than a professional distance and um... Well, they talk about malignant alienation, don't they? So, a patient is other. And... in some ways, a bit dehumanised actually, because otherwise, how would you cope with it?'

Drew (C, former prison doctor; national manager, prison health)

Again, the question of what coping strategies are viable for prison healthcare staff in these contexts is raised. This thesis does not condone staff's poor treatment of prisoners instead

highlighting that the repetition of this question indicates answers and the responsibility for answering, are not solely located within individual frontline practitioners. Drew continued:

> *'… you can end up with some pretty entrenched positions, where this sort of trauma is, is normalised [...] and this is where people get the compassion fatigue. It's the repeated behaviour. You try to go in and help, you try to assess the issues in a non-judgmental way, so you're not – when you're stitching, you're not doing it in a punitive way. I've heard about people not giving anaesthetic when they've stitched as a sort of bad dog approach, a behavioural approach to, which you know, it's shocking. […] [but] when it's chronic and repeated, I think people get frustrated when their attempts to help prove ineffective. And of course, you're not going to solve 30 years of trauma in six weeks, so... er... it's understandable that our attempts are not immediately successful. And this is a... relapsing, remitting condition, if you want to call it a condition.'*
>
> Drew (C, former prison doctor; national manager, prison health)

Drew also chooses to use the example of repetitive self-harm being a trigger for malignant alienation. There could be other ways for prisoners to express '30 years of trauma' (Drew) and other ways for staff to process and mitigate their frustration and anger: but it is channelled through alienation. This results in detachment, a lack of empathy and even, in punitive practices, e.g. not giving anaesthetic. Where staff are working in a context of pressure, paucity and pace, with ongoing yet extraordinary demands of them, staff aim for functionality by becoming alienated from their internal worlds. These alienated staff then alienate and dehumanise those they work with, in a further bid to retain functionality. This study suggests the alienation from self and from prisoners, has opposite effect, exacerbating poor outcomes for those who are suicidal and self-harming.

6d) Prison healthcare staff become dehumanised

The previous section demonstrates how staff's attitudes and practice can become so desensitised to the patient(prisoner) that the patient(prisoner) becomes dehumanised, treated as "other" and malignant alienation can occur. The final section of this chapter argues that prisons dehumanise not just the prisoners, but also the staff within them. Officer studies highlight the dehumanisation of prisoners: it was insidious and resulted in officers psychologically distancing themselves from those incarcerated (Scott, 2012) and/or prisoners becoming viewed as primarily 'objects of risk' to be managed (Arnold, 2017: 285). Findings from this study highlight the insidious dehumanisation of prison healthcare staff. This is a contribution to knowledge of this thesis. It suggests prison healthcare staff are alienated from themselves and others, that these collective prison pressures dehumanise staff who may then unwittingly pass this on to those in their care. This then can create further harms and inhumane prisons, despite staff's desire and efforts to offer compassion and hope in individual cases. Participants in this study shared statements such as 'you don't go to work to do a bad job' (Hilary: B, senior national role, health and justice). This highlights staff intentions may vary and/or that there can be a disparity between staff intention and the practice they are able to deliver in the prison context. Staff are dehumanised by the prison in a variety of ways which gradually erodes their own sense of humanity: this surfaced in the previous section on desensitisation, 'we become robots' (Casey: A, former head of healthcare). This final section of the chapter will consider how prisons dehumanise the healthcare staff within them over time, exploring implications for working with prisoner suicide and self-harm and beyond individual interactions.

6d.i) Organisational dehumanisation

In many prisons, 'care, compassion and humanity have been squeezed to the point of nonexistence' (Sim, 2021: 120) caused by structural issues that 'create and maintain patterns of dehumanization' (McLeod, 2015: 1173). Prison stigmatises, making the person with stigma 'not quite human' (Goffman, 1986: 6). Alongside material deprivations, imprisonment creates a 'more profound hurt' as a person's conception of themselves as a 'person of value… begins to waver and grow dim' (Sykes, 1958: 79): self-dehumanisation. As previously noted, data from this study suggests the presence of malignant alienation and othering of prisoners by some prison healthcare staff. Dehumanised prisoners experience denial or subjugation of 'autonomy, agency and subjectivity' (Bell and Khoury, 2011: 171). But is prison

dehumanisation applicable to staff? Foundational sociologists discussed the workplace as dehumanising, e.g. Weber considered workplace bureaucracy to be dehumanising, orientating workers towards the organisation, therefore alienating them from themselves (Weber, 1905, 2001). More recent scholarship has noted a broader understanding of dehumanising and its effects, 'dehumanizing perceptions enable harm or provide support for it' (Haslam, 2021: 139). Organisational dehumanisation is a 'result of a process, experience, or attitude' where someone is 'made to feel less human', with subjugated autonomy and 'made to feel like a tool or an instrument for the organization's ends' (Bell and Khoury, 2011: 170 and 171). Dehumanisation can be *animalistic*, e.g. comparison of people to cockroaches during the Rwandan genocide or *mechanistic*, e.g. people as robots or units of productivity, 'the objectifying denial of essentially human attributes', which is 'often accompanied by indifference, a lack of empathy, an abstract and deindividuated view of others' (Haslam, 2006: 262). Other people can be *perceived* as not human, as distinct from being *treated* as not human (Demoulin *et al.,* 2021). Data in this study suggested staff experienced organisational dehumanisation. Staff were mechanistically dehumanised through others' perceptions, e.g. a number to fill a rota slot, and how they were *treated*, e.g. being expected to finish a shift irrespective of events. The next section considers this mechanistic dehumanisation of staff in greater depth.

6d.ii) Mechanistic dehumanisation

Prison healthcare staff are dehumanised by prison, prison healthcare organisations and by a justice system that cannot accommodate practitioners' humanity following prisoner suicide and self-harm, resulting in mechanistic dehumanisation. Prisoners' mechanistic dehumanisation has been previously highlighted, '"you have to be a robot, not a human" to cope with […] prison life', noting there 'was "never enough time to sit down with an officer", and the environment often felt unresponsive to requests for practical help' (Liebling *et al*., 2005: 149). This study develops this previous work regarding prisoner dehumanisation, noting the language of mechanistic dehumanisation highlighted by Liebling and colleagues was found in data from prison healthcare staff.

A robot…

'Some people will cope the other way and go – right, I'm just warning myself

off from this altogether - and just seem like an automaton.'

Alex (B, senior prison health expert and prison doctor)

… with never enough time…

'… if I could wave a magic wand, it would be the […] sit them down for five, ten minutes and actually find out what's really going on for them and get them engaged in the process. Get them, spend more time hearing what they say to us about what will make it better for them.'

Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

… in an unsupportive environment.

'… the lack of recognition and support for the environment they're working in. And that, how tough that can be really to be in a closed incarcerate, incarcerated environment'

Sheridan (B, range of senior national health and justice roles, past and present)

The prison mechanistically dehumanises, both those incarcerated and working in it.

Prison healthcare staff descriptions of feeling less-than-human in this study could be categorised in three groups: i) how staff were (not) supported following involvement in suicides and self-harm – *perception* ii) poor *treatment* by management (generally) iii) poor *treatment* by prisoners. Elements one and two will be primarily explored here. Staff experienced poor treatment generally in a variety of ways: being purely a 'slot filler' (Lee), being undervalued and unsupported, a lack of respect for work/life boundaries and being badly treated during recommissioning cycles. This was at times in tandem with being on the receiving end of abuse from prisoners. The combined impact was an emotional hardening. Lee commented:

'I thought that just shows you don't value me, you just are looking for the slot filling. For my nursing colleagues, they are forever being phoned up on days off or if they're on nights they get a call during the day, just "can you please come

in? Could you extend?" I've known, one of the Band 7 colleagues was, was at a funeral and "can you just come in when you're back?" […] and if you've got, if you're feeling that that you are a number - whether that's a prison member of staff or whether that's - plus you are experiencing quite a lot of the outfall and the behaviour of people who have had very broken lives and there's a lot of abuse and dealing with the fair amount of violence, it does... how do you cope? You, you shut your emotional self off and you come in and you work and it can make you into a very hardened person.'

Lee (B, senior prison health expert and prison doctor)

Poor treatment by management is demonstrated by a lack of regard for staff boundaries, time off and life outside the prison, even when for funeral attendance. Here dehumanisation was quite literal: foregrounding the healthcare staff member's usefulness to the workplace whilst life-outside-work, crucial in conceptions of staff as human, are ignored, 'you are a number' (Lee). As explored in section 4c of this thesis, austerity policies have impacted prison healthcare and its commissioning, with staff shortages being common (House of Commons Health Select Committee, 2020; Council of Europe, 2020) and staffing numbers being reduced to an 'unsafe level' (Ismail, 2020a: 1372). Prison commissioning creates conditions whereby staff can feel like units of service and/or productivity, contributing to cycles of mechanistic dehumanisation. Staff then recalibrate to sustain themselves at work, subjugating their emotions, further distancing, alienating themselves from themselves, their feelings and those they work with, dehumanising the prisoners in their care.

6d.iii) Perception and treatment of staff – human or units of productivity?

Senior management perceptions of prison healthcare staff had consequences for the expectations and treatment of staff following prisoner suicide and self-harm. Previous studies found 'quality of life for staff', which included fair treatment, being valued and good communication, 'was significantly related to staff effectiveness in suicide prevention' (Liebling *et al.,* 2005: 191). Data in this study supported this. Participants made the link between valuing staff and keeping prisoners safe. Drew stated:

'If you drive patient safety, you have to drive staff involvement and valuing your

staff and making them want to progress in this environment. And, by its very nature, that will help to humanise the [prison] population.'
Drew (C, former prison doctor; national manager, prison health)

Participants understood the consequences of treating staff as units of productivity, rather than human: staff attrition, sickness and occasional poor practice. Max highlighted the dangers:

'… if you don't support your staff in a decent way they will leave […] going onto an app and looking at ways that I can be, can do mindfulness for 10 minutes is not, is not gonna support me through traumatic events. So, I think when you see organisations going above and beyond what the baseline is, that's really positive from my perspective.'
Max (C, former RMH nurse; senior health and justice lead)

Max here highlighted the limits of some support tools, noting the importance of staff feeling supported by another human being. Following prisoner suicide or self-harm, staff often experienced immediate support as available, but this dwindled over time, with data containing scant references to longer term support, leaving staff feeling overburdened and undervalued. There can be a virtuous circle created in perceiving staff as valuable as human beings and not just as 'slot fillers' (Lee, as above). Management valuing staff, in all their humanity, led to staff wanting to improve practice and stay in the role, which could improve safety outcomes for the prisoners they worked with.

Many participants noted the lack of institutional support following attempted or completed prisoner suicide. Once again, the onus was often on the individual participant to seek help or their peers were expected to offer support, rather than experiencing any kind of systematic time away from work or support offer. This subtly shifts the responsibility from being one of the workplace or employer in supporting their team, to be being that of an individual, who needs to make sure that they personally are "coping". Hilary noted:

'And we are humans at the end of the day, and I know in healthcare we always

talk about we need to adopt the airline model of investigation and root cause analysis. If anything like that happened in the airline industry you're taken out of duty for two or three weeks while all that happens.'

Hilary (B, senior national role, health and justice)

Other participants highlighted the powerful expectation on healthcare staff to keep going without pausing to interrogate that expectation, due to the pressures and pace of prison healthcare.

'The team manager did very briefly say, "are you okay?" But it felt a bit like a tick box, but then rushing me out and not actually wanting me to give an answer about whether I was okay or not, but I, I put that down to just that again, the fast-paced environment, that people just don't really get a chance to stop and actually think sometimes.'

Sammy (A, former prison psychologist)

In prison contexts it was challenging but essential to aim to offer time and /or space for a human response, albeit a human-in-the-workplace response to a prisoner death from a fellow staff member. The lack of thought that results from such a fast pace of work leaves staff, even in the aftermath of suicide, unattended to. Sullivan reflected on the expectation that staff would continue their shift after learning about a suicide:

'I think, looking back now, I feel like it's insanity that there wasn't like any real support around that [suicides and self-harm]. I think I felt quite comfortable asking for support. I think I was quite open talking to colleagues but it was business as usual.'

Sullivan (A, former frontline VCS healthcare worker)

The lack of routinised support minimises the fact the self-harm and suicide should not be routine. The participant used strong language, illuminating the 'insanity' of not offering support to staff working with suicide and self-harm and promulgating the illusion that this is best "managed" alone, responsibilising frontline staff. Ignoring the needs of the workforce and

neglecting to provide institutional support following a suicide invisiblises and dehumanises staff.

Participants also experienced dehumanisation in the perfunctory way they were informed of prisoner suicides. Sullivan continued:

> *'I came into a death in custody notice that was literally pinned on the key cabinet. This is how you find out someone is dead in prison, you go to draw your keys that morning and someone's photocopied their name onto a piece of paper. Which was, I think that in and of itself, like how you are told people have died is very hard... […] This kind of, yeah like just keep on, just go on and that feels... yeah, insane, now I think about it after the fact.'*
> Sullivan (A, former frontline VCS healthcare worker)

The mode of notifying staff about a prisoner's suicide dehumanises the prisoner and the staff: the photocopied notice does nothing to esteem the subject of it, nor care for or esteem the person reading it. The lack of support and then the expectation that the working day goes on regardless, seems nonsensical and dehumanising, leaving no space for any difficult staff responses or feelings. Staff members were expected to function as a robot or a cog in the machine. Long-serving staff in the study, Alex and Fin, were clear about the issues of accessing humanising support in prisons:

> *'I think lip service is paid to it, but these "nice things to have", fall by the wayside with the chaos that ensues, because you would like to have the debrief, but you can't because you're dealing with an emergency on another wing. Or like I said, you've got reception to deal with or it's actually 4:30 and the Head of Healthcare has just gone home or it's the weekend, you know?'*
> Alex (B, senior prison health expert and prison doctor)

> *'… at my level, sometimes you're lucky to get regular clinical supervision and reflective practice because you're so blooming busy that normally it's the first thing that bites the dust when there are 400 other things knocking*

at the door!'

Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

As outlined in chapter 4, the pace of prison healthcare – means frontline staff seldom have sufficient recovery time after suicide, either within the shift or longer term. The pace and volume of work, without supportive spaces to be a human who needs to process and understand what has happened, mitigates against the humanity of the workforce. Even where staff desired additional support, they lacked time to consistently access it, instead being drawn back into work and productivity, reinforcing mechanistic depictions of their role, contributing to their own dehumanisation as they aimed to function under prison pressures.

6d.iv) Dehumanisation: insidious but interruptible

As laid out above, staff dehumanisation can lead to hardening, further alienation from self and others. Despite the *intention* of staff to do a good job, their *practice* can at times be at odds with compassionate healthcare intentions. Fricker (2018: 55) notes 'that non-deliberateness does not entail non-culpability', and staff have agency to halt the insidious creep of dehumanisation in themselves and others. Kerry talked through the processes they saw unfolding through prison healthcare staff self-protection and coping:

'… those things can, over time, become very insidious and impact on the way that people do their job, it's a self-protective mechanism, but it can be very difficult and it's ultimately self-destructive. So, it's a way of shutting down things, but ultimately makes you more at risk from mental health problems and also possibly becoming less, less good professionally than you need to be.'

Kerry (B, former prison doctor; senior national role, health and justice)

As noted in 6b) Acclimatisation: detachment, staff may protect themselves by 'shutting down' (Kerry), having negative impacts on practice. To prevent these cycles of disconnection and dehumanisation, routes need to be found for trauma in staff to be acknowledged and addressed. This seems unlikely in the current climate, where the chronic under-resourcing can lead staff to be dismissive of suicidal and self-harming prisoners. Kerry continued:

'…are they [prisoners] able to get the support they need? You know, the unanswered call bell. That situation of people being seen as - ohh he's just seeking attention. Troublemaker, he's just... and how many tragic cases have we seen where there's those notes made in the court? So, I understand why those things happened because again, in traumatised, under-resourced situations, people will revert to that sort of, being irritated by calls for help, feeling overwhelmed and not being able to do things, and seeing somebody as attention-seeking as a sort of shorthand for dismissing them. And <u>those</u> things trouble me because there is something behind that that represents a lack of humanity.'

Kerry (B, former prison doctor; senior national role, health and justice)

Dehumanised staff, overloaded, traumatised staff can become unintentionally complicit in the dehumanisation of the prisoners. Innocuous coping strategies can become hardened into desensitisation, alienation and dehumanisation; then staff respond to suicidal prisoners with irritation, inertia or dismissiveness, demonstrating 'a lack of humanity' (Kerry). Despite practitioner intent, the realities and pace of prison interrupt, creating divergence between intent and practice.

'… it's not necessarily about people going into work with the plan to do a bad job. I'm sure most people have involved in these situations are caring human beings, but the way that we're asking people to do this work, the way that we are or are not resourcing them and supporting them, all is contributory to that series of events that may lead in that moment of desperation being transferred into, you know, a successful suicide outcome if you want to use that sort of phrase, but rather than something that could have been maybe less impactful in terms of loss of life or just ideally translated into an opportunity to engage with somebody, to change that outcome.'

Kerry (B, former prison doctor; senior national role, health and justice)

The unseen contributory factors – the institutional and structural, underpinned by the governmental – that trigger processes towards prison suicide are highlighted here. The lack of

resources and staff create pressures affecting how staff are able to work with prisoners in all their healthcare complexity, including suicidality and self-harming. In keeping with the processual ontological lens of this thesis, the data above offers hope, through consideration of the 'series of events' Kerry noted a point for intervention. Through taking the 'opportunity to engage with somebody', one way to halt the damaging cycles of dehumanisation of prisoners and staff was highlighted. Cycles of increasing dehumanisation are not inevitable. Other parts of the data contained examples of humanity, compassion, good practice and staff persisting in their humane treatment of prisoners. Max reflected:

> *'… as people are written about you get a feel for who they were and yeah, it'd be probably easier if they were anonymised and depersonalised, but I think actually you have to write about these as people because they are people have taken their own lives in prison and people shouldn't die in prison.'*
> Max (C, former RMH nurse; senior health and justice lead)

Dehumanising prisoners may minimise the emotional impacts on the practitioners, but it also diminishes responsiveness to people dying by suicide in prison. Prison institutions that encourage staff to respond mechanistically to prisoner suicides, denying feelings and returning to work with the aim of productivity hardens and dehumanises staff, again diminishing responsiveness to people dying by suicide in prison. As highlighted by Kerry and other data, dehumanisation is not inevitable. Other paths can be taken. This theme is further explored in Chapter 8: Pockets of Hope.

Conclusion

This chapter answers all subsections of the research questions, as it explores the continuum of acclimatisation of staff, which encompasses both enduring and cumulative impacts and effects initial responses to the next incident of prisoner suicide or self-harm. Conceptualising an acclimatisation continuum is an original contribution to knowledge. The continuum has strategies that retain the human-ness of staff at one end, through phenomena more prevalent in the data of normalisation, detachment, desensitisation and dehumanisation. Practitioners are and were working in broken institutions with a lack of accessible mental health care and

inadequate tools to reduce self-harm and/or tackle the deeper causes, so normalising self-harm was commonplace and an easily accessible as a coping strategy for staff. This thesis created novel conceptions of detachment as temporary, chronic and/or acute to enable a deeper understanding of detachment and its utility in demanding workplaces. The second part of the continuum – desensitisation and dehumanisation – were consequences of normalisation and detachment. Desensitisation had implications for staff practice and findings demonstrated staff were less responsive and complacent, and, in some cases, demonstrated examples of malignant alienation. As well as potentially dehumanising prisoners, prison healthcare staff could become dehumanised. This is a contribution to knowledge of this thesis. Prison healthcare staff were alienated from themselves and others, with collective prison pressures dehumanising staff who may then unwittingly pass this on to those in their care. This could create further harms and inhumane prisons, despite staff's desires and efforts to offer compassion and hope in individual cases. Normalising self-harm and detachment from internal worlds diminished the hope of recovery and the idea that things could be different. That made it more difficult for staff to hold the possibility of a different way in mind and negatively influenced the care they provided. However, the acclimatisation continuum is dynamic, the insidious slide into dehumanisation was not inevitable, it can be interrupted. The next chapter explores staff who worked with prisoners who completed suicides, meaning they needed to attend coroner's court; this contributes to subsection b, exploring the enduring effects of their work.

Chapter 7: Coroners' courts: distress, delay, deflection and damage

Introduction

This chapter concerns prison healthcare staff experiences of coroners' courts. Participants were keen to convey the serious, enduring implications of attending inquests for themselves, their colleagues, their practice and for those in their care. It is important to include the experiences and impacts of coroners' courts following completed prisoner suicides on prison healthcare staff: they are integral to these experiences. The findings in this chapter were unexpected, it was not anticipated that experiences from coroners' courts would be so salient to the lives of participants nor that it would generate a whole chapter of novel findings and analyses. Specifically, the chapter addresses part b of the research question about the enduring impacts of this work. Processual ontology here stimulates a fuller exploration of the range of (f)actors implicated in prisoner suicides and subsequent inquests. "Factors" is not used to eschew 'determinist dystopias' without the hope that agentic actors may yet enable change (Tomczak, 2022a: 497). Instead, (f)actors indicates the importance of agentic human actors, whilst keeping the processual ontological lens, that non-human factors also contribute to the experiences of coroners' courts and the impacts of those attendances. Data demonstrated prison healthcare staff experiences of coroners' courts were stressful, distressing and created anxiety. Organisational understanding, preparation and support could offer a degree of mitigation. These experiences were further compounded by delays, jury's poor understanding of prisons and adversarial inquests that were blame-seeking, responsibilising individual staff, deflecting from structural and political (f)actors in prisoner deaths. There were damaging consequences for prison healthcare staff practice arising from inquest experiences, anxious staff lacked confidence and developed avoidant practice. Time is particularly salient in this chapter with coronial inquests threatening from the future to affect staff practice in the present, with delays exacerbating enduring deleterious impacts on staff and contributing to staff attrition, with negative implications for prisoners' care. Findings in this chapter originate from the wide-ranging damages created by coroners' courts, radiating beyond the staff that attended inquests to colleagues and prisoners. Damage was experienced across temporal scales – before, during and after inquests – creating enduring impacts, such

as anxious, avoidant practice and staff attrition, resulting in poorer care for suicidal and self-harming prisoners.

All deaths in custody or state detention are referred to the coroner's court, as stipulated by clause 1.2.c of the Coroners' and Justice Act, 2009. Unlike most coronial inquests, the inquests of those who die in state detention are served by juries. Coroners are responsible for 'matters of law and procedure', with juries deciding 'the facts of the case' and the 'cause of death' (Ministry of Justice, 2020: 27). Coroners' inquests are deemed to be inquisitorial, tasked with understanding the circumstances of an individual's death, how, when and why they died (Tomczak, 2018). They are devised as a "fact finding" exercise, though more accurately the facts and verdicts they create are 'a product of a long and complex process beset with negotiations and interpretations' (Liebling, 1992: 88). Prison healthcare staff can be summonsed to attend coroner's court as witnesses and may be questioned by a variety of legal representatives (Wright, *et al.,* 2012). Coroners' courts are meant to avoid the adversarial nature of criminal and civil courts, with questions of liability and blame attribution allegedly outside coronial remits (Baker, 2016). Coroners can pass evidence to the police or Crown Prosecution Service should civil or criminal proceedings be deemed relevant, and, although liability cannot be determined by coroners' courts they can 'record facts that make it clear that the death was caused by a specific failure of some sort or by neglect' (Coroners' Courts Support Service, 2024). Indeed, staff are aware they 'may be subjected to nit-picking cross-examination by lawyers whose inflexion of voice may be none too deferential' (Knapman, 2006: M35). There is limited scholarship on coroners' courts: what exists is primarily concerned with their processes, critiques of these and the experiences of family members attending them. Staff's perspectives, people who are 'at the sharp end of events, policies, procedures, and often – of public and academic criticism', have still been seldom sought (Liebling, 1992: 69). Therefore, there is a research lacuna regarding staff's experiences as witnesses and any personal and/or professional implications. This chapter speaks to this research gap. It begins by examining how staff are prepared for and experience coroners' courts, before considering the compounding stressors of delay, difficulty due to poor prison understanding and deflection. It ends by looking at the consequences of these experiences for the staff and the prisoners in their care.

7a) Coroner's court appearances

The limited literature surrounding staff experiences of coroners' courts, including prison officers and from wider healthcare settings, suggested attendance for professionals at inquest can create 'considerable anxiety' (Liebling, 1998: 72). They are deeply stressful (Borrill *et al.,* 2004), seen as adversarial (Baker, 2016; Snow and McHugh, 2002) and blame-seeking (Banwell-Moore *et al.,* 2022; McKendy *et al.,* 2021). Prison staff spending long periods of time in coroners' courts consequently further depletes staffing resources (Banwell-Moore *et al.,* 2022), with inquests often viewed as creating 'more stress than the incident' itself (McKendy et al., 2021: 10). The implications and harms of from coroners' courts reach wide cohorts of prison and prison adjacent staff (Aitken, 2022; Banwell-Moore *et al.,* 2022). The literature regarding healthcare professionals attending coroners' courts is focused on preparing those practitioners for attendance. Two papers address the experiences of prison healthcare staff attending coroner's court: firstly, a 'viewpoint' paper, outlining the limited international literature on clinicians as witnesses at coroners' courts (Wright *et al.,* 2012). Secondly, a broader paper explores the experiences of 'public safety personnel' - a category that included prison healthcare workers, around two potentially psychologically traumatic events, one of which is a 2019 Canadian prison death (Ricciardelli *et al.,* 2022). This latter paper notes the urgent need to support staff called as witnesses and recommends a range of testimonial modes to minimise cross-examination. The authors themselves describe their work as 'limited… experientially acquired knowledge', drawn from 'informal and formal conversation rather than an empirical study', and argue that further study is needed in this area (Ricciardelli *et al.,* 2022: 6). Data from this study agrees with extant scholarship that shows staff experience coroners' courts as stressful, distressing and anxiety provoking. Importantly, a finding here was that stress, distress and anxiety occur in a wide staff cohort, not just the person attending the inquest. The following section develops this work to consider how organisations aim to mitigate these experiences, before sections exploring compounding stressors and onward consequences.

7a.i) Stress, distress and anxiety

Attending coroner's court as a witness created stress, distress and anxiety for prison healthcare staff. In addition to the limited extant scholarship explored in the previous paragraph, research about non-prison healthcare professionals attending coroners' courts is illuminating. Nursing staff cite attendance as nerve-wracking (Teng, 2013). Psychiatrists can find them stressful (St. John-Smith *et al.,* 2009), anxiety provoking (Calthorpe and Choong, 2004), overwhelming (van Dellen *et al.,* 2022), unhelpful and traumatic (Gibbons *et al.,* 2019). Participants in this study affirmed this, identifying feelings of stress, distress, anxiety and sometimes resulting trauma in relation to attending coroners' courts. Experienced staff still found inquests fear-inducing and stressful because of the variables of each case and the range of unknowns around questioning. Chris shared:

> *'I would absolutely shite myself if the coroner said can I see, can he see me? I would shit myself […] Particularly if they wanted to see me at [name of senior role] level, there's some serious shit going on. If they wanna see me, therefore that's not gonna be an easy ride. So, I think it's - yes negatively, in that way, coroner's court will just, makes you go like "oo-err-eeeeee-ooooo", like that.'*
>
> Chris (C, former nurse; senior health and justice manager)

From the summons to the inquest itself to the aftermath, involvement with coroners' courts elicited visceral responses across the cohort of participants. Along with anxiety, staff stress and distress recurred in data. Fin recalled her experiences:

> *'I think of going to court… it's not just the fact it's just a stressful occasion […] One, it's distressing because somebody's died, and that's not what we go to work for. Secondly, it's stressful because you're going into the unknown really. You know you're going into coroner's court, but you never quite know what the questions are that you're gonna get asked. […] And I think the other thing is that most people, probably, when they're there, trying to do the right thing, are always thinking about all the stuff that's stacking up at work…'*
>
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

There is a striking acknowledgement that prisoner suicide provokes distress and is antithetical to the reasons staff work in prison healthcare. The stresses "in the room" of the coroner's court, are added to by stresses mounting "out of the room" at the prison, with staff away from current prisoners to attend an inquest about a past suicide. Staff attending inquests lessens already diminished staffing levels, potentially creating further harms to prisoners. Stress, anxiety and distress are experienced by staff in the coroner's court which can seep out to their prison workplaces, to those they work with and their future work selves.

Distress also reached the colleagues of those attending coroners' courts creating secondary distress, that is staff distressed by their colleagues' distress. This is like Banwell-Moore *et al.*'s (2022: 7) finding that the 'trauma of suicide radiated beyond the prison' to Prisons and Probation Ombudsman investigators. In this study, the distress of attending coroner's court inquests, radiated beyond the time and space of the inquest to a wide range prison healthcare staff. Watching a colleague in distress, grappling with the memories and feelings evoked by inquests, weighed heavily on other staff, including those beyond emergency responder roles.

> *'And I've had the unfortunate experience of seeing staff crying, because when they step down [from the witness stand] it's so distressing and, and that is hard to bear. For whatever reason, they are distressed. Partly because it's a reminder of the deceased, they might've actually been attending the deceased for weeks, months or even years before their death. And the death might distress them, or partly because they do feel that the service let them down, or partly because they recognise that they did actually have a part to play and something to do with that person's care, which has just been touched on.'*
> Taylor (C, senior health and justice staff member)

Revisiting the traumatic details of a person's death can be potentially re-traumatising (Ricciardelli *et al.,* 2022). Participants in this study referenced several reasons for witnesses' distress: they worked closely with the deceased person, the nature of death was upsetting, fear of unknown consequences, staff felt unsupported and/or they felt (partially) responsible

for the death. Coroners' court attendance is stressful, anxiety provoking and distressing and these responses are experienced in a wider staff cohort than just those called to the inquest.

7a.ii) Preparation, support and mitigation

Prison healthcare organisations were cognisant of the stress, distress and anxiety provoked by coronial inquests. Organisations prepared their staff for possible attendance at coroners' courts in the following ways: supported drafting of initial statement, role play, legal and pastoral support. Prison healthcare practitioners called to inquest 'may have little training or knowledge of what to expect' (Wright, 2012: 92). These interventions aimed to reduce fear of the unknown and mitigate the more difficult elements, e.g. cross-questioning, and provided a rehearsal for court. Staff valued organisational approaches that prioritised learning and shared accountability. For example, when preparation began early: managerial staff highlighted the importance of drafting statements quickly following a death, whilst memories were sharper and easier to recall. Drew commented:

> *'And you can do your very best to prep people, right from the word go when we do the, the clinical case review a week or ten days after the incident. I'm encouraging people to write their statements at that point while it's all fresh.'*
>
> Drew (C, former prison doctor; national manager, prison health)

As well as being written as contemporaneously as possible, managers valued statements being robustly drafted, cognisant that they can be thoroughly interrogated in court should the staff member be called as a witness. Lesley highlighted the importance of this and the implications of failing to do so:

> *'… staff really need to understand what they've written in their statements and give a good account for what they put in their statement and not just hope that if they turn up they can read their statement because they're not – they are going to get questioned on it. So, they need to understand it inside out and I don't think staff fully understand that all the time and as a result, they might get tripped up by a question and that just keeps tumbling,*

tumbling, tumbling.'

Lesley (former RMH, senior national health and justice manager)

The depiction of staff falling downwards, unravelling because of a poorly considered statement, is striking. Preparation from the outset is key, so staff understand how their written statement may be used in court. The other main forms of preparation cited were more embodied methods, immediately prior to the inquest: visiting the court room ahead of time or role-playing with mock inquests, mimicking the experience of cross-examination. Ludlow *et al.,* (2015) noted the role of visiting the court room ahead of time to aid staff preparation for inquest. As noted in 7a.i, involvement in coronial inquests was viewed as stressful, distressing and anxiety-provoking. Practitioners who had traumatic coronial experiences that endured, could use these positively once in managerial roles. Chris spoke about using their experiences to help prepare staff:

'I set something up a few years ago when I worked for (name of organisation) which was, um, we worked with a, with a solicitor that we used with deaths and he came in and he did some training and we did mock, mock inquests and we this, you know, you'll be asked to swear on a Bible, you'll be asked to put your hand up, you'll be... and so I did this programme of when there was a death and so there's some positive things too, because I, I mean, I didn't, you know, really understand coroner's either.'

Chris (C, former nurse; senior health and justice manager)

Taking staff through the order of events and procedures that constitute a coronial inquest helped to deepen understanding, as well as prepare staff for difficult questions. Mock interviews helped staff reflect upon and consider the range of different ways they could answer questions, and aid their understanding of triggering information. Preparation supported staff understanding of coronial processes and could mitigate some aspects.

Alongside preparation, data contained references to the importance of pastoral and legal support for staff before, during and after inquests. Solidarity amongst prison staff can be both 'a resource and a protection' (Peacock *et al.,* 2018: 11). Staff in this study highlighted the

importance of feeling supported by peers and management when facing inquests: drawing on the resource of solidarity to protect and mitigate the difficulty of inquests. Pastoral support could be informal, e.g. a kind word, a colleague noticing or asking about an upcoming inquest, making space in the day to talk. Sullivan reflected:

> *'I was supported by the healthcare team, the deputy head of healthcare was very nice to me and took me out for cups of tea and cigarettes and told me I was going to get legal representation and came too. Like there was a few of us had to go to coroner's court but I felt fairly robustly supported in that way.'*
> Sullivan (A, former frontline VCS healthcare worker)

Informal "time out" in the workplace, e.g. cigarettes and tea, are cited in another study as a method for staff coping whilst at work with repetitive prisoner self-harm (Walker *et al.,* 2017). In a highly pressured workplace, staff still found microspaces for solidarity, using quotidian strategies to sustain them whilst working with suicides and the inquests that follow. The combination of pastoral and legal support enabled staff to feel well supported. Legal support could include preparatory work ahead of taking the stand, training, deepening staff's own understanding of coronial processes. One participant commented that they had even trained as an expert witness to '*mitigate*' the *'whole trauma of the inquest experience'* to '*arm themselves with the games that barristers play'* (Lee: B, senior prison health expert and prison doctor). This provided a snapshot of the lengths staff went to, to prepare themselves for appearance at coroners' courts, an experience they expected to find traumatic and combative. Sasha commented:

> *'… we have consistent members of the legal team supporting our staff and Preparing our staff, right up and through, but we also marry that with a senior member of the team […] to be available to support […] But what's really changed is the experienced legal support, that know both the legal system but also understand the importance of ensuring staff give a good, fair and obviously truthful account of themselves when taking the stand…. There's so many, so much of them as well. As I say, go back to busy locals or those busy prisons - just how much time is spent on legal? It's <u>a lot.'</u>*

Sasha (C, senior health and justice manager)

As explored in this thesis in 4c.iii staff were working at an increased pace due to greater workplace pressures and a paucity of staff. Data surrounding coroners' courts demonstrated preparation and attending inquests placed another demand on staff's time. Strong support for staff with thorough legal input is laudable, yet it creates another pull away from core healthcare functions, including working with prisoners who are currently suicidal and self-harming. Further research is needed to determine how healthcare organisations cover staff absences when they are preparing for or attending inquests, and the proportion of prison healthcare staff time dedicated to inquests. Pastoral and legal support served to equip staff and alleviate fears, anxieties and stress ahead of court attendance. Solidarity with others was powerful. Groups of individuals were navigating broken systems, attempting to mitigate staff distress from attendance at coroners' courts, which is generative and hopeful. Yet the time, effort and money expended on inquest preparation and support is problematic. It removes staff and resources from current prisoners. Putting time, effort, energy and money into addressing wider systemic issues, e.g. high rates of imprisonment or the low numbers of healthcare staff, correlated with prisoner suicides and subsequent inquests would reduce initial and subsequent harms. It is critical that staff are well supported when attending inquests to mitigate potential trauma and significant impacts on their lives, yet it is another example of misdirected investment triaging victims of broken systems, rather than tackling the systemic issues correlated with prison suicides.

7b) Compounding stressors contribute to harms

Coroner's court attendance created stress, anxiety and distress amongst staff, which could be mildly mitigated by strong support and preparation. However, far more commonly in the data were factors that *compounded* the initial stressors of attendance. Bereaved families found coronial processes exacerbated their grief reactions, e.g. feelings of shame, anger, sadness (Biddle, 2003). Novel findings from this study demonstrated coronial processes characterised by delays, difficulties due to jury miscomprehension and deflecting blame onto individual staff, exacerbated the impacts of attending inquests. Extended waits for inquests increased prison healthcare staff distress, anxiety and contributed to additional harms, e.g. increased trauma

and further pressures on prison healthcare organisations. The public's low-level understanding of prisons created difficulties for witnesses, with coronial juries failing to grasp the context of prisons in crisis, as well as the current scale of self-harm and suicide in prisons. Finally, this section explores the compounding stressor of combative blame cultures in coroners' courts, which place emphasis on individual actions - responsibilisation, deflecting attention from structural and governmental failures. Delays, difficulties and deflection compounded already tough experiences, affecting the individual, their colleagues, their practice and, in some cases, career trajectories, with further implications for prisoners in their care.

7b.i) Delay - extended waits

Extended waits for inquests also exacerbated prison healthcare staff stress, distress and anxiety whilst contributing to additional harms, e.g. increased trauma and further pressures on prison healthcare organisations. This is a novel finding for an empirical study. A study of psychiatrists reported that long delays in getting to coroners' court could increase fear and distress (Gibbons *et al.,* 2019). For prison officers, delays meant 'lengthy periods of uncertainty and anxiety' (Liebling, 1998: 71). Across staff groups and relatives, time delays can be a 'stressful burden' (Roulston *et al.,* 2021: 13). Chapter 4 noted that healthcare staff experienced DiMaggio and Powell's (1983) idea of coercive isomorphism, being healthcare staff within the dominant prison culture, resulting in a temporal truncation: a faster pace. In this chapter, coercive isomorphism leads to temporal elongation: delays. Witnesses are subject to coroners' courts in pressurised processes and, in comparison with the host court, witnesses' 'legitimacy is relatively weak' (Robinson, 2022:214). Witnesses must work with the time frame dictated by the court. The faster pace demonstrated in chapter 4 and the delays discussed here, demonstrated prison healthcare staff's precarious, contingent temporal capital; defined as 'the amount of time individuals or groups have under their control' (Wang, 2019: 1555). Staff may, for the most part, have greater temporal capital than the prisoners in their care, but many aspects of their work, across scales are out of their control, e.g. the timings of dispensing medication through to delays at coroner's court. Extended waits for an appearance at coroner's court means inquests can haunt staff *before* and not just *after* their occurrence. Data demonstrated the pressure of the *'… processes that then hang over you'*, Alex (B, senior prison health expert and prison doctor). Coronial processes, with myriad unknowable implications, haunted staff and created further anxiety.

Participants could wait three or four years for cases to come to inquest. Additional to practical concerns of acuity of memory, there is prolonged uncertainty regarding a potentially psychologically traumatic event. Lesley noted:

> *'… we're talking in some cases, three years, four years, before it gets to coroner's court. Now, as good as your memory might be, it's not gonna be as crystal clear four years down the line, is it? And I just think the staff then have to relive that, they've really lived it here and re-lived it with the, the clinical reviewer from the PPO, they relived it with our internal investigation […] it doesn't go away until the until the inquest has been concluded. And that could be two years, three years, four years. And, and staff having to deal with that, and I don't know how we, we measure that. And I'm not sure that we're good at checking in with them – how, how they're doing with that.'*
>
> Lesley (C, former RMH, senior national health and justice manager)

Data here highlights that staff may be re-traumatised in retelling their experiences to different strata of investigators, as well as noting the lack of resolution that they felt pre-inquest. Alongside noticing the implications on individual staff pending inquests, data indicated a wider range of institutional impacts. Prison healthcare organisations struggled to support staff appropriately over these extended - multi-year - periods, particularly given the prevalence of prisoner suicide, self-harm and the likelihood of more incidents that then eclipse previous deaths. Staff could be signed off sick or deeply preoccupied whilst at work, contributing to staff pressures and/or compromising the quality of care to prisoners. Staff were frustrated that the time lapse meant coroners identified failings in prison that were long-since noted by earlier investigations, often with mitigating actions already dispatched. These elongated time periods led to querying the efficacy of coroners' courts and their ability to reduce prison suicides, whilst acknowledging the importance of coronial processes to those bereaved. Delays at coroners' courts left prisoner suicides feeling unresolved, embedding enduring consequences for individuals and institutions.

7b.ii) Difficulty - poor public/jury comprehension of prison

Another compounding stressor raised by prison healthcare staff was the public's low-level understanding of prisons, creating difficulty for witnesses facing coronial juries. Coroner's court's juries are selected and summonsed to jury service through the same mechanism as criminal court juries: 12 randomly selected people from the electoral register (Gov.uk, 2024a). They are held in public, unless there are national security concerns (Snow and McHugh, 2002). Jury members are allowed to ask witnesses questions through the coroners (Ministry of Justice, 2020). Examination of case studies demonstrates juries drawing conclusions such as 'the prison staff should have been more vigilant,' without querying what caused a lack of vigilance, e.g. low staff numbers, high numbers of prisoners with open ACCTs (van Dellen *et al.,* 2022: 190). Data from this study demonstrated the difficulty of communicating to laypeople the demands faced by frontline prison healthcare workers and the perception of what was within staff's remit and control. At times, juries believed other courses of action were available to staff, which staff maintained were not. For example, Hayden shared this story of a prisoner on hunger strike:

> *'… they [the jury] were asking quite gnarly questions. I think there was some uncomfortable moments […] The judge just said "look, he's given you an answer. Move on" […] the guy was he was sort of on self-imposed hunger strike before he before he hung himself. And one of the issues was, we're allowed to take a meal in and encourage people, but couldn't force him to eat it, I mean we just weren't equipped for that sort of stuff, or it wouldn't have been ethical and all the rest of it. And one of the jury wasn't happy that we weren't trying harder to make the guy eat. […] the implication was we, we didn't care. Which isn't really fair actually at all.'*
>
> Hayden (A, former mental health nurse)

Prison healthcare staff working with suicidal prisoners are required to make judgements, balancing the personal autonomy of the prisoner, restricted as prisoner autonomy is by incarceration, and aiming to prevent death. The jury member in the data above misconstrued what was within the power of the healthcare staff, resulting in further judgements on staff's attitudes towards the prisoner in their care. Fin shared a similar experience:

'… when you feel like you're living in the coroner's court and you're standing there in the witness box and everybody's firing questions at you and the jury questions sometimes are just so bizarre, because they don't understand. They're, people in the community sometimes are great ones for saying "lock them up", "Throw away the key", do this, do that, do the other, but they don't understand that actually, we can't stop people from watching televisions just because they've got epilepsy and we can't stop them from eating sweeties, just because they're diabetics. They just think that because they're in prison, we can stop all those things […] And we can do all this sort of stuff. They just don't get it, you know? There's many an occasion where I've really wanted to say to people - I didn't do this job to watch people go out the gates in the box. But that's sometimes, that's the impression that you get left with... It's like everybody is almost saying that, you all did a rubbish job and that, you killed these people and that's just so far from the truth, so far from the truth.'
Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

These experiences were draining and frustrating. Repeatedly prisoner autonomy is overlooked by juries due to a lack of understanding about prisons. This exacerbates the difficulties of attending coroner's court inquests and, as with Hayden, Fin also correlated this with juries thinking they 'didn't care' (Hayden) and had done a 'rubbish job' (Fin). Staff vigorously contested such perceptions yet these slights on their competency and care created additional distress.

Coroners' juries were often unaware of the challenge to staff presented by unprecedented rates of prion suicide and self-harm (Ministry of Justice, 2024a). These rates elevated pressures to repeatedly, consistently make the "right" judgement call, at speed, in complex circumstances, with errors being potentially catastrophic. Sullivan explained:

'And, it sounds really callous, but, I'm trying to explain that at coroner's court to the lay people was, is kind of impossible to explain. Like, you don't understand, I've got 90 men on an open wing, 60 of them telling me they're

going to cut themselves. How do I assess who is serious and who I need to give my attention to? […] And when you're being asked questions of but how did, why did you not give him an extra five hours of support? Or why did you not do this? These kind of questions we're trying to explain - that's not how prison works. And I'm trying to explain to people like, we have we have 30 ACCTs open on one wing sometimes, you have to use your judgement to decide who needs your attention.'

Sullivan (A, former voluntary sector prison healthcare worker)

Staff's professional judgement and their ability to make good decisions is crucial in attempting to manage caseloads and needs that exceed the available hours in a working day; suicide prevention cannot rely on consistently perfect staff judgement calls. Prison healthcare staff attending inquests experienced juries as removed from the realities of prison, which added to their stress when accounting for their actions. Staff felt that coroner juries could only partially grasp the contextual implications and scale of prisoner suicide/self-harm, meaning questions and/or verdicts were misinformed and misdirected.

7b.iii) Deflection - combative blame cultures obscure governmental factors

Combative blame cultures, including adversarial cross-questioning, were compounding stressors which deflected attention from governmental factors in coronial processes following prisoner suicides. Coroners' courts are distinct in law from civil and criminal courts, they cannot determine liability and they ostensibly work on a fact-finding inquisitorial basis (Liebling, 1992; Tomczak, 2018). However, The Coroners' Society's memorandum of understanding with the PPO notes 'The process is inquisitorial, but [..] incorporates some adversarial procedures. […] Questioning at an inquest may be robust' (PPO/CSEW, 2012: 6). Aitken (2022: 487) suggests that inquests may become more adversarial 'when a death may have revealed inadequate action on the part of the state or a private security company responsible for running a prison'. Data in this study demonstrated inquests were experienced as adversarial by prison healthcare staff, consistently going beyond questioning downplayed as "robust." Psychiatrists who appeared as witnesses at coroner's courts named cross-questioning as a primary contributor to harms experienced. It was 'negative, intimidating and uncomfortable' (Wright, *et al.,* 2012: 95). Being a witness can be 'more or less painful

depending on the response and attitude of the psychiatrist's trust, the family of the deceased and the coroner,' with persecutory experiences having enduring effects on staff (Gibbons *et al.,* 2019: 237). Findings from this study extend these psychiatrist-specific findings and demonstrate their relevance to a range of prison healthcare staff across roles and grades. Data demonstrated experiences of coroners' courts ranged from negative, damaging, devastating to career ending. Blame and adversarial questioning were constant features. As Hilary observed:

> *'I think some coroners allow the inquest to become very, very inquisitorial and some of our clinical reviewers have also said it's been really aggressive questioning by barristers, which I'm not... And it has put people off. And I don't know how many staff might leave due to an experience of that of – couldn't put myself through that again…'*
> Hilary (B, senior national role, health and justice)

> *'The line of questioning, the cross examination, it's still very adversarial. You're sitting mere feet away from the family of somebody that's died in your custody and they want answers, whatever those answers are. And sometimes you don't have them.'*
> Riley (A, former RGN and senior healthcare manager)

> '*But when we, when we went to coroner's court, I was made to feel that I've murdered that man.'*
> Chris (C, former nurse; senior health and justice manager)

An already demanding and stressful experience was exacerbated by excessively adversarial and aggressive questioning. The combative nature of inquiry led to people leaving prison healthcare, which was bad for staff morale and resulted in a loss of expertise in staff cohorts, further compromising the delivery of healthcare to prisoners who were suicidal and self-harming. This is explored later in this chapter (in 7.c.ii). This style of questioning frequently sought to apportion blame to an individual responsibilising them, without acknowledgment

of the complex interplay of factors that are involved in suicides, particularly in state-run or state-contracted institutions.

Prison healthcare staff attending coroners' courts as witnesses experienced repeated attempts to locate blame for a prisoner's suicide on one member of staff, responsibilising that individual, rather than approaches that accommodated wider factors and accountabilities. Individual coroners articulated the complex range of factors and systemic hazards involved in prisoner suicide (Tomczak *et al.,* 2023). Yet prison discourses more broadly favour responsibilisation, that is, the 'state seeking to devolve responsibility… onto "private" organisations and individuals' (Garland, 1997: 190). Additionally, suicides - both in and outside prison settings - can be conceived of as individual choices, rather than of collective responsibility, consequently requiring no action from the state (Pantazis, 2016). A narrowing of suicide 'to the psychopathology of individuals' restricts discussion and 'stymies sustained reflection on suicide as a properly political question' limiting collective responses to 'the sociocultural conditions that help to foster suicide' (Button, 2016: 271). Suicides are commonly deemed the responsibility of the suicidal person, 'confined to the boundaries of the individual person' (Marsh 2010) or that of the 'healthcare professionals in cases where they are deemed to have acted negligently in response to the relevant risk factors' (Aitchison, 2024: 911). The location of responsibility amongst healthcare staff, which occurs immediately prior to and after a prison suicide, then *reoccurs* with the sphere of coroners' inquests, manifesting as blame. Coroners are instructed not to apportion blame, indeed the 'coroner should ensure that questions do not *suggest* blame', furthermore, if 'it appears that an issue of competence is being questioned the doctor can ask for an adjournment and seek legal advice' (Calthorpe and Choong, 2004: 150, emphasis added). However, data in this study repeatedly demonstrated experiences deviated from the coronial remits of fact finding without apportioning liability or blame. Fin commented:

> *'… it's not about apportioning blame. It's not about saying that people are rubbish, it's about actually trying to find out what the truth is. But it never feels like that when you're in the coroner's court. It never feels like that.'*
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

'And often the coroner's report or the PPO wants to be just sort of fact finding, non-judgemental and non-blaming when actually, that's exactly what they are.'

Jean (A, former prison psychiatrist)

The legal basis of a coroner's inquest can contrast with the lived experience, as participants in the inquest aim to identify a locus for the blame. The rhetoric-reality divide between policy/procedures and practice is present again, driven by coronial inquests that are insufficient to grapple with suicides when understood as greater than individual psychopathology or individual healthcare practitioner actions. Participants highlighted that the search for someone to blame did not end with the person on the stand and that persecutory cross-examination could implicate other prison healthcare staff, diminishing staff solidarity. As previously noted in 7a.ii when considering how staff are supported at inquest, solidarity offered protection against the growing 'individualising of pain, suffering and resistance', responsibilisation, prevalent in the prison system (Peacock *et al.,* 2018: 14). Sullivan recalled,

'… there was the need to blame someone. So, if I explained myself really clearly […] it was then "oh, but what about your colleague?" And I felt like I was then expected to throw my colleague under a bus and I... […] it felt really like there had to be someone to blame and I get it, no-one should die in prison, we should at the very least be able to keep these people alive. I understand the need for real robust investigation, but when it doesn't take into account the reality being in prison... it was just incredibly horrible...'

Sullivan (A, former voluntary sector prison healthcare worker)

The adversarial and openly hostile cross-examination of individual practitioners creates an inhospitable setting in which to elicit understanding of the complex networks of accountabilities and contributing factors when considering prison suicides. The constant pursuit of individualised culpability was unhelpful in determining causative elements of prisoners' suicides. Sullivan continued,

> ‘*It was an incredibly horrible experience where I don't think we got the root of what happened. I don't, I wasn't left with any clearer understanding of what happened.’*
> Sullivan (A, former voluntary sector prison healthcare worker)

Staff experienced deep distress and at times trauma after attending coronial inquests. Yet often left feeling no clearer about the causes and potential routes - frontline, institutional or systemic - to prevent future deaths. Lee similarly commented on their experience as an expert witness at a coroner’s court,

> *‘I've looked and I thought hang on a second, I've done a lot of work on this case and I still don't think we've got to the bottom of this.’*
> Lee (B, senior prison health expert and prison doctor)

This data raises questions about the efficacy of coroners’ inquests both in terms of staff stress, time and diminished frontline resources, as well as the suitability of coroners’ courts to reckon with the complexities of prison suicides and/or to make recommendations that may prevent future deaths.

Prison healthcare staff - chiefly management and long-serving staff - identified prison contexts and institutional factors as crucial in establishing accountability for prisoner suicides. Inquests exhausted staff, which, combined with the ongoing pressures of the job, could diminish staff’s appetite to interrogate wider structural and political reasons for prison suicides. Interrogation of systemic reasons must remain a collective endeavour, served by actors across different scales and spheres, e.g. UN special rapporteurs, academics, charities. However, despite the restrictions on doing so, prison staff identified systemic hazards as contributory to prisoner death (Tomczak *et al.,* 2023). A study of PPO staff and coroners found the ‘problems are greater than the sum of individual prisoners’ distress or the actions of particular members of prison staff’ (Aitken, 2022: 480). This thesis supports and extends previous scholarship by examining prison *healthcare* staff experiences and within that, *management* experiences, focusing on how these interact with attending coroners’ courts and the allocation of blame. Within a combative, blame-seeking coronial system, data from this study demonstrated staff

experiencing accountability as shared across a range of actors. There was often a strong sense of team accountability where there had been a completed suicide. Taylor reflected on their experience of coroners' courts:

> *'… it'd be exceedingly rare for one individual to have actually influenced somebody's death – it's the team. And if one individual **has** influenced somebody's death, then the manager of that team is equally responsible. Because, I have a responsibility to know what my team does and each nurse is accountable to their line manager for what they're doing. So, I don't think that individuals can be held uniquely accountable, but of course you feel it when you're standing there, talking about what went on.'*
> Taylor (C, senior health and justice staff member)

The format of cross-examining individuals, whilst looking for a locus of blame, does not suit the model of shared responsibility described in the data above. The ontological framework of this thesis emphasises the contingent, emergent and dynamic nature of things and facilitates considerations of both the genesis and apportioning of blame. Processual ontology acknowledges "responsibility" for suicide should not be located within one individual – either the person who died or the healthcare practitioner who had worked with them – and 'opens up the "black boxes" of institutional operations and agents to investigate potential points of intervention' (Tomczak *et al.,* 2023). Data from this study contained examples of staff beginning to open "black boxes". Drew commented:

> *'… when we do our post incident reviews, I'm always at great pains to say that we're not criticising individuals, we're looking for where we can learn to improve our processes that makes sure that individuals do what's needed, because it's, there's so much to do and there's so much expectation. I don't think the same approach has taken in coroner's court. […] I'm really careful to own that as an organisation as well, rather than saying it, it sits with you. Sometimes people have done things that are so egregious that they have to be accountable, but what, what we aim for is accountable but no blame learning. So, you know, what was going on? What mitigations are there? Was*

it particularly busy? Had someone phoned in sick? Were you carrying two radios? And so on and so forth, and get all of that captured. But still people are terrified of going to coroner's court.'

Drew (C, national manager, health and justice provider, former prison doctor)

This data foregrounds the lived experience and significance of prison contexts when responding to suicidal prisoners. It identifies some of the practical reasons that protocols may not have been followed or why a staff member's judgement may have been impacted by ways of working supported by HMPPS and the state, e.g. understaffing resulting in carrying two emergency radios. Staff may at times be involved in 'egregious' acts, as also noted in chapter 6.d) dehumanisation, it is the prison context that negatively impacted staff practices. The participant stopped short of examining the structural and governmental issues such as policies for cover during staff sick leave or why numbers of prison healthcare staff so low that staff carry multiple radios. Data from this study demonstrates prison healthcare staff's engagement with contextual complexities when considering accountability for prisoner suicides, in a way that coronial inquests appear unable to.

As well as being ill-equipped to contextualise accountabilities for prisoner suicide, coronial inquests poorly examined structural and governmental factors, leading to a dearth of scrutiny of these aspects. The narrow focus on the 'responsibility concentrated attention on frontline actors with limited control of their work environments' meant that other (f)actors were 'unexamined and thus unaccountable, including central government officials' (Tomczak *et al.,* 2023: 27). Moreover, the use of investigative procedures, hyper-focused on the individual circumstances of the individual death, contribute to the depoliticisation of prison suicides and enable swerving of discussions about 'the meaning of pain in punishment' and *why* and *who* we imprison (Aitken, 2022: 493). Internal prison scrutiny in the context of austerity policies was 'ineffective' and external oversight, such as His Majesty's Inspectorate of Prisons and the Independent Monitoring Boards, 'misdirected [scrutiny]… towards governors in the form of management critiques' (Ismail, 2023: 161). This study develops previous findings to demonstrate that prioritising scrutiny of individual practitioners over holistic or root cause examinations, neglects structural contributors, underpinned by governmental factors. Indeed, 'Pursuing individualised accountability for past failures' restrains oversight bodies' potential

to reduce prison harms, including the prevention of suicides (Tomczak and McAllister, 2021: 217). As explored above, staff could contextualise prisoner suicides and cite institutional (f)actors; some raised structural, systemic (f)actors in relation to prisoner suicide and the inadequacy of the coronial processes in addressing these. Gurpreet noted,

> *'… we focus on what went wrong, on individuals, but we don't necessarily focus on the human factor. We don't focus on the system, so what's wrong with the system? It's okay to make mistakes, as long as you, you've done the best you possibly can. You've taken reasonable steps. Of course, when you're in front of the coroner's inquest […] it can feel very personal. Very blame culture. […] There's lots of different layers to this.'*
>
> Gurpreet (C, national manager, health and justice provider)

Neither coroners nor the PPO excel at identifying systemic hazards in prison suicides, e.g. the continuing remanding in custody of those with severe mental health problems (Tomczak, 2022b). Nor do they identify the governmental factors that underpin these structural issues, e.g. the lack of mental health beds, the higher costs of secure mental health beds compared with imprisonment, the increase in mental health crises, because of policy decisions over many years. Coroners can issue Prevention of Future Death (PFD) reports if the inquest demonstrates an ongoing risk that could contribute to other deaths (Cross and McArdle, 2016). Their PFDs usually concentrate on particular institutions and their actions. Coroners' 'external scrutiny' role and their ability to create reports 'means they are potentially significant agents of harm prevention' (Tomczak, 2018: 57). Though this is, arguably, often not the case (Baker, 2016;). The actions of individual staff should clearly form *part* of any prison death scrutiny. However, data from this study suggests that the highly visible prison healthcare staff were often absorbing strains caused by the less visible institutional, structural and governmental factors, which added to their burden. Visible prison healthcare staff became cyphers for scrutiny within coroners' courts, deflecting scrutiny from the policies that create the systems they operate within.

The complexity of prison systems, influenced by governmental factors, means it is unlikely that an individual is causative of another's suicide, yet coroners' inquests are ill-suited to the

recognition of collective responsibility and the complexities of accountability. Coroners' inquests are focused on blame and individual actions, as if such actions existed in a vacuum and not a social, political and ideological context. Thus, obfuscating scrutiny of structural factors, underpinned by governmental factors. Further work could consider approaches to scrutiny embedded in processual ontology that enable the opening of the "black box", so that a wide range of contributory (f)actors across scales can be identified and potentially mitigated. Rather than chastising a nurse undertaking receptions, who fails to identify a person as suicidal, mechanisms that considered the underlying decisions and policies that led to, for example, an inexperienced agency nurse, with limited relationships in the institution, working for their tenth consecutive day, with twenty incoming prisoners waiting to be assessed in prison reception. Could coronial processes account for 'the risk factors for suicide' impacted by 'the structural conditions in which people live, especially conditions that are marked by the intersections of poverty and various forms of social and political marginalization', which are 'powerfully influenced by a unique constellation of policy regimes and policy effects' (Button, 2019: 87)? The location of blame in individual practitioners at coronial inquest is another example of the effect of atomisation of responsibility in the prison system: responsibilisation. There are immediate and ongoing implications to this. The over-emphasis of the role one staff member played created extraordinary pressures, impacting the individual, their colleagues, their practice and, in some cases, career trajectories, with further implications for prisoners in their care. These consequences will be discussed in the following section.

7c) Damaging consequences for practice and beyond

Staff testifying to coroners' courts can be profoundly impacted by their experiences, with consequences for their practice. Suicide can 'distort[s] the clinician's view of him or herself and their clinical practice for a long period afterwards' (Campbell and Hale, 2017: 95). Data from this study demonstrated that attendance at coroner's court could distort the clinicians view of themselves and affect clinical practice. Describing an inquest experience Chris stated:

> *'I think if you've had a bloody awful one like that it, it changes you forever.'*
> Chris (C, former nurse; senior health and justice manager)

After inquest completion, prison healthcare staff experienced cumulative and long-term effects from appearing as witnesses. Testifying in coroners' courts can be 'challenging, mentally draining, and difficult (with many collateral consequences)' for staff (Ricciardelli *et al.,* 2022: 6). Data from this study supports and extends this finding to consider the nature of these consequences. Staff experienced anxiety and a lack of confidence following inquest attendance. A wider group of staff experienced anxiety about potential future attendance at coroners' courts, which could lead to avoidant practices and thereby minimise the chance of being summonsed to coroner's court. Staff knew prison healthcare staff were more likely than healthcare staff in other settings to need to appear before the coroner, due to their double burden of risk. Data repeatedly demonstrated that staff left following traumatic inquest appearances. These nascent findings could provide foundations for either ethnographic or longitudinal studies further exploring over time, the wide spectrum of negative impacts and outcomes correlated with coroner's court attendance for staff and prisoners in their care.

7c.i) Damaging consequences for practice: anxiety and avoidant practice

Prison healthcare staff, irrespective of whether they have attended coronial inquests as a witness, may amend their practice to minimise the chance of being summonsed to coroner's court. This is distinct from staff amending their practice to reduce prisoner suicides. Previous scholarship suggests staff giving evidence at coroner's inquest can be negatively impacted, which may prevent them from being able to 'confidently continue practicing prison healthcare' (Wright, *et al.,* 2012: 95). Findings from this study agree, attendance at coroner's court damaged staff confidence. This study extends extant work, noting consequences for a wider group of healthcare practitioners *who may not have attended* a coroner's inquest, who may also amend their practice. Such practice includes poor record keeping and deliberately omitting engagement with prisoners in documentation to avoid potential summons. In prisons with many staff, working different shifts, clear and effective communication between staff is a core part of suicide prevention. Additionally, keeping good medical records are a 'vital part of patient's present day and forthcoming health care' (Amin *et al.,* 2020: 550). Omissions in record keeping can have serious consequences for prisoner healthcare and the prevention of suicide and self-harm. Low confidence, anxiety and avoidant strategies associated with

attendance at coroners' courts created harms for the healthcare practitioner and those in their care.

Prison healthcare staff confidence and decision-making was negatively affected in the weeks and months after a difficult inquest. Prison staff can experience crises of confidence following prisoner suicide (Slade *et al.,* 2019) and, as explored in 5a.iv of this thesis, after delivering life-saving interventions. Data demonstrated coronial inquests could also diminish staff confidence in the workplace. Chris describes their uncertainty:

> *'… the whole thing was just really, really traumatic. So after that, I... um, […] I just went through about six months of... um... being unsure of myself […] the issue for me was not the death. The issue was the treatment at the coroner's court […] and how I was made to feel.'*
> Chris (C, former nurse; senior health and justice manager)

Other colleagues cited that uncertainty and anxiety led to overuse of processes like ACCT. Scholars have noted that where 'fear of liability for deaths was high and staff did not feel confident in using discretion, a dependency on ACCT had developed' (Ludlow *et al.,* 2015: 40). High use of ACCT can compromise the effectiveness of it in preventing suicide, as explored in 5c.ii of this thesis. A lack of confidence can lead to a reliance on procedures, rather than observation, knowledge and expertise. Jean noted:

> *'… they become a bit more obsessional about sort of making sure things are done. So, none of these things probably save people, but they make people feel…less anxious maybe? The practitioner. […] I think some people are very anxious, very conscientious. They will say conscientious, but they've become purely anxiety filled and they've become overly anxious in their work.'*
> Jean (A, former prison psychiatrist)

Completion of ACCT procedures can become primarily about allaying staff anxieties, rather than suicide prevention. Even when staff that had no personal experience of attendance, the

cultures of anxiety surrounding coroners' courts had consequences for them and their practice.

As noted above, anxieties about coroners' courts could lead to over-compensation in record-keeping; conversely, it could lead to omissions and avoidance, to the detriment of care for prisoners who were suicidal. Anxieties surrounding attendance at coronial inquests led to omissions from notes and avoidant behaviour in emergency call-outs. Lee summarised:

> *'I think that the trauma also of scrutiny, that there will be people who don't want to go to attend an attempted hanging because they don't want to be, have their fingers on, in there when they end up in coroner's court or, there's a huge amount of risk aversion because of the level of scrutiny and because of how very unpleasant it is, being in an inquest and being in this adversarial process.'*
>
> Lee (B, senior prison health expert and prison doctor)

Whilst avoiding coroners' courts may be understandable, healthcare staff being slow to respond to an emergency code on the radio could have life-changing or life-ending consequences. Practitioner hesitation in *present* emergencies due to fear of *future* coroners' inquests based on traumatic *past* experiences, is deeply concerning and signals the urgent need for reviewing of coronial processes to halt the creation of additional harms. Participants contextualised these fears in the realities of time pressures from soaring caseloads, record-keeping requirements and awareness of the potential future litigation. Lee continued:

> *'… you're allocated no time at all, but you're expected to see 14 patients […] you're expected to write in the notes for each of those 14 patients. And then you're also expected to write and find out about how all patients in the inpatient unit are and that's all before clinic starts... But every time you're writing in notes you're thinking, "I need to make this watertight" because you're working in a very litigious environment. Plus, this sort of super traumatic scrutiny.'*
>
> Lee (B, senior prison health expert and prison doctor)

Practitioners cannot alleviate the fears and anxieties that generate avoidant and poor practice alone. Staff work with unfeasible caseloads, determined by government policy and organisational tenders in systems that are reliant on administratively burdensome paper trails and reduce the time practitioners have to spend with prisoners. Record keeping and audit trails are prioritised over the delivery of healthcare because of reasonable fears of litigation or action against a practitioner by their professional body. Whilst still the numbers of prisoner suicides remain high. Staff may amend their practice to enable them to stay working in prison healthcare, even within such conditions and expectations. Many staff do not. Instead they leave. It is this consequence of coroners' courts that is considered next.

7c.ii) Further damaging consequences: risk and retention

Traumatic experiences at inquests had a deleterious effect on staff retention. This recurred in the data. Prison healthcare staff carried greater risk than their hospital or secure environment healthcare counterparts. This could be a factor in influencing staff's decisions to leave. Participants gave examples of colleagues resigning whilst waiting to appear at inquests, as well as after inquests, to avoid risking exposure to further prisoner suicides and more appearances at coronial inquest. As noted in the introduction to this chapter, staff can be subject to civil and criminal cases, as well as other investigative procedures, such as those by the PPO or professional medical bodies such as the Nursing and Midwifery Council. Yet consistently, the most cited, feared and likely to cause staff attrition was the coroner's inquest.

It was more likely for someone working in prison healthcare to attend coroners' inquests because of the parameters in 1.2.c of the Coroners and Justice Act 2009 that 'the deceased died while in custody or otherwise in state detention.' This higher likelihood in prison healthcare, rather than in hospital healthcare, and having to give an account of yourself and your practice before a coroner can be distressing and off-putting. Gurpreet noted:

> *'And then I think the staff do feel they're carrying a lot of risk compared to, say, a mental health team or an inpatient unit where there's a lot more resources to manage and intervene, self-harm. Whereas in a custodial setting, you've got high numbers of incidents, you've got much less resource. So you*

carry more risk, so if something goes wrong there is a, there is a genuine anxiety about going in front of the coroner's court.'

Gurpreet (C, national manager, health and justice provider)

As noted in 4a.i of this thesis, healthcare staff in prison are working with more frequent and severe levels of self-harm, on a larger scale than their colleagues in analogous settings. They do so - as noted in 4c of this thesis and by Gurpreet above - with less 'resources to manage and intervene.' As previously outlined, imbalances between demands and resources can lead to long-term stress (Finney *et al.,* 2013). A finding of this study is that a discrepancy between demand and resources leads to a double burden of risk for prison healthcare staff. Drew commented:

'… we're about to mobilise [names redacted] sites and one of those I've been speaking to some doctors who currently run the service and asking them if they would consider continuing. And two of them have said no because of the risk, the clinical risk and the risk of ending up in court, so... and that's GPs. […] there is an effect from the investigative process […] And it's another barrier to recruitment and retention.'

Drew (C, national manager, health and justice provider, former prison doctor)

Staff working across secure healthcare understood the heightened risks for prison staff. As with findings in every chapter in this thesis, the experience of coroners' courts was foregrounded by the pressured prison contexts of 21st century England and Wales. Alex articulated their frustration:

'I can't remember having had a conversation with somebody that hasn't had members of staff leave after a coroner's inquest. It's just so predictable […] it's extraordinarily damaging. […] That impact is just unmeasurably, immeasurably draining, the absolute loss of huge, huge numbers of staff because of the numbers of deaths we've had, which seems which seems a very... I appreciate the person is lost, they've lost their lives and their families lost their family member. But how can we care for people? It's this,

the process of investigating every death as we currently have also causes us to lose the people that, that are really, really, really trying to do their best under extraordinary circumstances to care for people.'
Alex (B, senior prison health expert and prison doctor)

The exasperation, anger and desperation of senior staff at the vicious circle that is created by harrowing investigative procedures, including inquests, was clear. Attrition of experienced staff because of traumatising experiences at inquests has implications for the healthcare delivered to the next prisoner. Recruitment of healthcare staff to prison is challenging, but enabling those who have built skills, knowledge and experience over many years to stay, is increasingly difficult. A different approach - aiming to reduce the double burden - could be adopted. Greater resourcing of prison healthcare: more staff to enable better ratios of staff to prisoners, could reduce risk through increased staff temporal capital and the autonomy to linger in interactions with prisoners in their care. At present the high likelihood of attending coronial inquests was an immense challenge to the retention of prison-based healthcare workers.

Data demonstrated that attending a coronial inquests could be more damaging for staff than their experiences of prisoner suicide. Staff watched colleagues leave, sometimes after one inquest. Riley commented:

'We have people leaving service because of the fear of coroners, or the fear of having made a mistake, even a very small mistake. […] I think you regularly see it a lot when it comes to coroner's court and you're looking at the lists and who's being called um – gosh… he doesn't work here anymore. She doesn't work here anymore. She left after this. He left after that…'
Riley (A, former RGN and senior healthcare manager)

Staff highlighted how inquests were damaging, burdensome and blame-seeking, causing the predictable outcome of staff leaving prison healthcare. It was presented as a commonplace response to an incredibly traumatic experience:

Participant: *'Not that they were blamed at the corners, but they felt attacked through the process […] So it's a massive outpouring of people who want to work with these populations that no longer do, as a result of experiencing the processes […] the constant thought of those processes pending around you is, is really unpleasant […] people might leave. I've seen it load times in psychiatry, nurses, healthcare assistants, doctors – all left.*

Interviewer: *And is that because of the impact of the suicides or the impact of the consequent PPO or coroner's investigations?*

Participant: *I think with <u>all</u> of them it's to do with, <u>more</u> to do with the consequences of the suicide, than the suicide itself. I don't think you can work in mental healthcare and not think about suicide, but we know you are more at risk… […] It's the processes that really push people to move.'*
Jean (A, former prison psychiatrist, emphasis in the original)

For some, patients dying, sometimes by suicide, was an anticipated part of the role: sad but not wholly unexpected. Inquests and adjacent investigative procedures may also be part of the role; but these investigations being deeply unpleasant and damaging, need not be. Staff did not protest external scrutiny but sought alternative and less devastating means to enact it.

The adversarial cross-examination of prison healthcare staff resulting in staff leaving, set in the current context of some of the highest recorded rates of prison violence and self-harm, re-iterates the need for greater focus on the structural and system causes of prisoner deaths. This supports Aitken's (2022) suggestion that there are limits to accountability predicated on individual details of cases, particularly at times of prison crises. He concludes that this broad spectrum of issues is 'greater than the sum of individual prisoners' distress or the actions of particular members of prison staff' (Aitken, 2022: 480). This study extends Aitken's work highlighting that there are there limits to the coronial model of accountability, it is harmful for staff and prisoners, and is counterproductive. Alex concluded:

'So, it [coroner's inquest] feels like an extraordinarily weak part of the system […] there are no winners here, there are no winners. And that somehow seems wrong. It is, in its own way. Seems like an act of self-harm.'

Alex (B, senior prison health expert and prison doctor)

Coronial inquests can offer some solace to bereaved families and friends and are an important part of the landscape. However, in their current format, overshadowed by the pursuit of individualised responsibility, they can become another site of harm and self-harm within the justice system.

Conclusion

Coroners' court attendance is stressful, anxiety provoking and distressing for staff, beyond those called to the inquest. Preparation and support offer mild mitigation against some of the adverse impacts of attending coroners' courts. Whilst it is important that staff are well supported to ameliorate impacts on them and the prisoners they work with, it is another example of misdirected investment triaging victims of broken systems, rather than tackling the systemic issues correlated with prison suicides. The salience of temporality recurred within this chapter, whether the elongated time frames experienced waiting for coroner's inquest which embedded enduring difficulties for staff, or staff acting in the present out of fear of an anticipated future. The reach of coercive isomorphism of the coroner's court and into prison healthcare staff, coupled with responsibilisation, was significant. Delays, difficulties and deflection compounded what were already difficult experiences, affecting the individual, their colleagues, their practice and with further implications for prisoners in their care. These delays highlighted the precarity of prison healthcare staff's temporal capital and led to staff querying the efficacy of coroners' courts and their ability to reduce prison suicides. Inquest juries were often far removed from the realities of prison. Visible prison healthcare staff became cyphers for scrutiny within coroners' courts, deflecting scrutiny from the policies that create the systems staff and institutions operate within. Prison healthcare staff who testified to coroners' courts could be profoundly impacted by their experiences: these experiences also have consequences for practice. Staff, irrespective of whether they themselves have attended

coronial inquests as a witness, may amend their practice to minimise their chance of being summonsed to coroner's court. Low confidence, anxiety and avoidant strategies associated with attendance at coroners' courts created harms for healthcare practitioners and those in their care. Traumatic experiences at inquests had a deleterious effect on staff retention. The adversarial cross-examination of prison healthcare staff resulted in staff leaving, set in the current context of some of the highest recorded rates of prison violence and self-harm, this re-iterates the need for greater focus on the structural and system causes of prisoner deaths. The contribution of coroners' courts to reducing in prisoner suicides is questionable, which deviates wildly from the intention. Evidence of prisoners harms increases. Further exploration using processual ontological lenses, offer ways to open the "black box" of coroners' courts and untangle the vicious circles of harms created, identifying moments for intervention and aiding the alleviation of suicide in prisons.

Chapter 8: Pockets of Hope

> *'Hope rises out of known suffering and is the defiant and dissenting spark that refuses to be extinguished… Hopefulness is not a neutral position. It is adversarial. It is the warrior emotion that can lay waste to cynicism. Each redemptive or loving act, as small as you like… keeps the devil down in the hole.'*
> (The Red Hand Files, 2022)

Introduction

This chapter explores the cohort of prison healthcare staff who were able to negotiate an exceptionally tough workplace by using strategies and habits to sustain themselves within it, *and* deliver compassionate healthcare to prisoners who self-harmed and/or were suicidal, at least *some* of the time. These were unexpected findings from inductive data analysis and created innovative contributions to knowledge within this chapter. These strategies and acts staff used are to be read and understood in the context of the preceding chapters that chronicle staff's moral injury, disenfranchised trauma, dehumanisation and more, with poorer outcomes for prisoners in their care. The inclusion of this chapter is ontologically important – these small acts, habits and strategies create *pockets of hope*. For hope to be possible there needs to be 'faith in the potential of the individual (the opposite of cynicism) and a link to reality, to the realistic possibility of positive future outcomes' (Liebling *et al.*, 2019: 122 and Van Hooft 2011). The chapter is included to emphasise the hopeful, emergent nature of the processual ontological approach adopted, for 'Inside the word *emergency* is *emerge*; from an emergency new things come forth' (Solnit, 2004: 13 – emphasis in the original). This chapter does not suggest that relying on individual practitioner's pathfinding, creating pockets of hope, in a broken system is the optimal mode for addressing entrenched, systemic issues. It is included to highlight the hope and potential for change, and to illuminate the good practice, in amongst the crisis and chaos of 21st century prisons.

As noted in the introduction to this thesis, there are rising prisoner numbers, enduring staffing shortages and a reduced funding settlement following government austerity policies (Ismail, 2020a). To recap, working with high levels of suicide and self-harm increases pressures on staff (Marzano and Adler, 2007; Slade *et al.,* 2019) and prison employee post-traumatic stress disorder rates are equivalent to war veterans and higher than police officers (James and Todak, 2018). Decades before the current crisis in the prisons of England and Wales, Foucault wrote about prison as a 'death machine', stating 'The whole penal system is essentially pointed toward and governed by death' (Foucault, 2002: 419). He goes on to explain how 'the desire for death' travels with those imprisoned both during and after incarceration, so whether you continue to live or not following a prison sentence are 'two expressions [that] mean the same thing' (Foucault, 2002: 419). Prisons can be places of death, that damage, fracture and separate. Foucault's ontological perspective stymies a more detailed examination of the processes, the how and why prisons and/or their staff become places of death and damage. Rather than viewing the dynamic, contingent, processual nature of things, that means dying and damaging are mutable, interruptible processes. As noted by Marzano and colleagues (2013: 12) staff having '… negative reactions to self-harm are not inevitable'. Data in this thesis supports this contention and extends it to demonstrate that people are still able to act and work in ways that may cause change, that retains the potential for other ways of being and doing, even if that is hard to realise in the present. In highlighting these pockets of hope this chapter seeks, in a small way, to contribute to further discussions, ideas and actions, across scales and actors to reduce prisoner suicide and self-harm and their associated harms.

Staff experiences of prisoner suicide and self-harm were varied, so too were their responses to working in this environment. One participant articulated this difference explicitly, Sullivan began:

> *'So, there was like 30% of the people I worked with in the prison were amazing, absolutely wonderful people who were just like far nicer people, more patient than I could ever be in my whole life and they seemed great. I think there was a middle ground 30% who were incredibly stressed by the job, didn't really know what they were doing, and that's through no fault*

of their own, I just think they were thrown in because we were always short on staff and it was like "come in. Here's your keys, get doing your job". And we kind of knew they'd be gone soon anyway. And then 30% who just didn't really care […] so it didn't seem to bother them in quite the same way. But they're the ones I always thought weren't coping because they just pretended they didn't care and pretended it's completely normal when all this like horror's going on. So, I was always like – God, […] they must have some deep-seated issues.[…] I'd say 30% of people who were "I hate prisoners, I hate it here, I don't care he's cut his wrists" kind of thing, I was like - ohh God, they've got some real issues.'

Sullivan (A, former frontline VCS healthcare worker)

As stated in chapter 3, Research Design and Practice, the sample in this study was not necessarily representative of all prison healthcare staff, it was comprised of people with long prison work tenures and those who had a particular interest in the reduction of prisoner suicide and self-harm. Therefore, most of the cohort here is likely to have drawn from participant Sullivan's group of 'amazing, absolutely wonderful people': e.g. those who had not grown entirely disenchanted with the possibility of alleviating prisoner suicide and self-harm. Mindful of this context, this chapter explores five pockets of hope. Staff were expressed being squeezed, yet still sentient. These staff were sustained by: finding their work meaningful, taking action to improve other health outcomes, collegial trusting, and talking and being witnessed. Apart from finding work meaningful, these "pockets" all provide original contributions to knowledge.

8a) Squeezed, yet still sentient staff

Given the 'toxic dehumanisation induced by the prison environment' (Sim, 2021: 120), data in this study still contained multiple examples of staff humanity, compassion and curiosity, challenging the notion of 'the systemic indifference of many prison staff' (Sim, 2021: 120). It is a novel contribution of this thesis to demonstrate that staff could be tenacious in attempts to reduce prisoner suicides and self-harm over long prison health careers with positive

implications for their colleagues and prisoners, e.g. halting the slide into dehumanisation highlighted in chapter 6. Data also contained praise for colleagues working in challenging prison conditions, in counterpoint to the claim that 'care, compassion and humanity have been squeezed to the point of non-existence' in prisons (Sim, 2021: 120). Whilst data from this study support the contention that 'care, compassion and humanity have been squeezed' in prisons, it was not 'to the point of non-existence' (Sim, 2021: 120). Eliding the institution of prison (though Sim makes an exception of HMP Grendon) and all prison staff into an amorphous uncaring whole is unhelpful and unhopeful. As with Foucault's death machine, this fixed ontological perspective again constrains examination of the processes, ignoring that organisations exist in a 'constant state of flux' and thus minimising the potential for change (Watson, *et al.,* 2021: 213). Systemic changes such as reducing rates of imprisonment and increasing resources to prisons could enable changes on a swifter, larger scale, contributing to upholding the humanity of staff and prisoners alike. However, healthcare staff are working with prisoners in struggling prisons every day, acting in each moment in ways that could benefit or harm, however unwittingly, those they work with. Sim's approach reduces the identification of routes through the current desecration in prisons, to a future where staff and prisoners may at least be afforded the possibility of being human and treated humanely, rather than routinely dehumanised. Neither is Sim's assertion reflective of the data in this study: prison healthcare staff suggested that they were indeed squeezed and yet still demonstrated capacity for care, compassion and humanity.

8a.i) Staff under pressure but capable of feelings

In a system that squeezes those who live and work in it, healthcare staff could act as shock absorbers for prison brutality, with deleterious impacts on them (as explored in the previous chapters). The term squeezing here indicates the impacts of the wider contexts and pressures on staff: squeezing is inherently dynamic and contains possibilities of change, particularly should the contexts and pressures improve. Participants highlighted their continued sentience – that is their ability to feel and their awareness of that – even when working with high levels of prisoner suicide and self-harm. Staff demonstrated awareness of their own acclimatisation – which they noticed as normalisation – and yet retained some emotional connectedness. Staff could be capable of professional curiosity, despite constraints explored in chapter 5; they showed consciousness of emotions evoked by prison work in themselves and other

colleagues. These had not been 'squeezed… to the point of non-existence' (Sim, 2021: 120). Staff also noticed colleagues who were detrimentally detached from their emotions, as highlighted in chapter 6. Fin reflected on several decades of working with prisoners who had died by suicide:

> *'I don't think I've ever got to the point where I've thought this is just a normal run of the mill day at work. I don't think I've become so blasé... I don't think I've become desensitised to it. I've become a bit more... pragmatic about it I suppose, and I think I've got a job to do. I've got to support the staff, I've got to do this, this and this […] I do reflect on it and I did spend a lot of time thinking about it and probably, if I really thought about it too much, I could probably sit and cry <u>now,</u> because some of them you think - this just shouldn't have happened.'*
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

> *'I've worked in prisons and I don't feel I'm desensitised to it. It's obviously pretty shocking. When I first stepped into prisons - to see the volume and level to which people would go with self-harm. So, I suppose I <u>am</u> desensitised, to a degree. But I haven't cut myself off emotionally from people to prevent me from trying to engage and understand and how to help them. […] Some people will […] go – right, I'm just warning myself off from this altogether - and just seem like an automaton.'*
> Alex (B, senior prison health expert and prison doctor)

Long-serving, senior practitioners reflected that whilst working in prison with suicide and self-harm had caused 'a degree' of desensitisation (Alex), that they had not become desensitised to it. Staff evidenced this by the retention of connection to their own emotions.

8a.ii) Colleagues important in retaining emotional connection

Staff also noticed this connection to emotion and humanity in colleagues. Sullivan observed:

> '*At least the really nice ones, the people who really cared about the job*

would be quite open with you and say, "oh, that was horrible, wasn't it?" Like there would be some humanity in that, which allowed me to think they were coping ok.'

Sullivan (A, former frontline VCS healthcare worker)

The data showed the role of *colleagues* in acknowledging the difficulty and emotions connected with working with suicide and self-harm, which meant practitioners could retain 'humanity' (Sullivan), and eschew 'automaton', non-human responses (Alex). This is explored further later in this chapter in iv) collegial trusting and v) talking and being witnessed. Participants were also quick to praise their colleagues, recognising their skills and attributes even in the context of systemic squeezing. Chris shared:

''… you have to be a very special person […] I think you have to be able to work under immense pressure and you experience things that you wouldn't experience in the "outside world". I mean, at the end of the day, prison healthcare, it isn't sexy. […] you have to be so highly skilled, so adaptable, so amenable. You have to have a heart of gold but nerves of steel...'

Chris (C, former nurse; senior health and justice manager)

'… the vast majority of people working in healthcare in prison are doing an amazing job everyday of their working lives. And that despite all those things we've talked about, the majority of people find ways to cope, find ways to get help, find ways to support each other. And we just need to make that a lot easier, so that it isn't down to – you're lucky to work in a nice team with nice supportive people around you.'

Kerry, (B, former prison doctor; senior national role, health and justice)

Data contained these examples of praise for colleagues, often from senior participants with decades of experience over multiple prison sites. Kerry highlights the need for consistency in systemic support, rather than the luck of the colleague lottery in supporting staff. This is particularly salient in prison settings where practitioners do not have easy access to wider support systems – family and friends – during the working shift because of the security of the

setting, e.g. restricted email access, no mobile phones. Kerry's claim that the 'vast majority' of healthcare staff are 'doing an amazing job' would need further research to establish it, but data here demonstrates that there are *some* quality staff delivering *some* quality healthcare in *some* prisons, for *some* prisoners: squeezed but still sentient.

8b) Finding meaning in work

Finding meaning in work was a powerful sustaining factor for prison healthcare staff working with prisoner suicide and self-harm. Extant studies with prison healthcare staff show that feeling effective at work gave work meaning and was the strongest indicator for job satisfaction (Garland and McCarty, 2009). Considering work meaningful was a protective factor against burnout (Kalra, *et al.,* 2016). In analogous sectors, where trauma was also encountered at work, work being meaningful acted as a 'buffer against the impacts' and had a protective role for staff (Crivatu *et al.,* 2021: 10). In secure forensic settings, mental healthcare staff's good relationships with their patient-prisoners, demonstrated by understanding, was shown to be crucial to staff finding meaning at work (Jordan, 2012). This finding agrees with and extends extant work to demonstrate that finding work meaningful, as measured by effective practice rooted in good patient relationships, helps sustain prison healthcare staff working with prisoner suicide and self-harm. It also considers the risks of disproportionate focus on the good achieved for a few prisoners to create meaningful work for the practitioner.

Following Jordan (2012), data in this study supported the centrality of practitioners feeling effective at work being rooted in good prisoner-staff relationships to create meaning. Participants were asked what they enjoyed about work, responses consistently mentioned: being effective, working with a prisoner cohort and making a difference. Chris commented:

> *'I love the stories. I love, I love the humanity. I love, I love... very occasionally being thanked by <u>the</u> person that was never going to thank <u>anybody.</u>'*
>
> Chris (C, former nurse; senior health and justice manager)

Alex expanded on the importance of good working relationships with prisoners enabling positive outcomes:

> *'I love the patients and love the relationships and building of relationships with people. And the progress that you can see that people are able to make. As a GP […] my experience has been – okay, you don't necessarily make a massive difference to everybody, but you certainly make a huge difference to a few.'*
> Alex (B, senior prison health expert and prison doctor)

Staff kept these positive experiences of making a difference at the forefront of their minds to carry them through the more difficult parts of their work. This supports the contention that 'individuals narrativize their experiences so that they can keep going amidst the struggles that define their realities' (Quinn *et al.* 2021: 384). Practitioners may be able to both foreground the positive and learn from other experiences, but there is a risk of an undue focus on the (less common) positive outcomes. Mel explained why feeling that *some* work activity *was* making a difference mattered when working with prisoner suicides and self-harm:

> *'… you've got to feel that you've made a difference in some other way, otherwise, you feel an overwhelming sense of guilt and I think most people, their ego puts them in a position where their ego has to protect them. It protects them by essentially saying, "you weigh that up with all the good that you do, you're a good person, you're doing the best you can, these things happen in this environment, it's not your fault." '*
> Mel (A, former RGN, head of healthcare and national health and justice role)

Knowing that parts of your work made a difference and was therefore meaningful was protective for staff against being overwhelmed by guilt or other disabling negative emotions whilst working with daily 'horrors' (Sullivan, as above). However, a disproportionate focus on "making a difference", may act as a protective blanket, muting critical faculties, reflections on practice and challenges to structural questions about *why* 'these things' – prisoner suicide and self-harm – 'happen in this environment' (Mel, as above). There are many things outside

practitioners' control in prison healthcare that may impact prisoners' suicide attempts and self-harming, e.g. the inability to get prisoners out to hospital appointments (Davies *et al.,* 2020). But other aspects, e.g. why the practitioner had an affinity with a particular prisoner, with reflection and learning, could enable amended practice to assist more prisoners, with potential for increased good outcomes than more than the exceptional few. Such reflections require time, space and support. In prison healthcare settings marked by pressure, paucity and pace (see chapter 4c), the protection of "making a difference" is an easily accessed narrative to sustain oneself, much in the same way that the normalising self-harm is (see chapter 6a.ii). The next section considers how prison healthcare staff seek to do this in work that is so characterised by prisoner suicide and self-harm.

8c) Taking action: avenues for improved outcomes

Staff sustained themselves by finding avenues for creating improved health outcomes, ideally measurable ones, within prison healthcare to balance their chaotic and unpredictable work with prisoner suicide and self-harm. Previous studies evidence staff's feelings of powerlessness (Karman *et al.,* 2015; Marzano *et al.,* 2013; O'Hara *et al.,* 2021; Patterson *et al.,* 2007; Saunders *et al.,* 2012; Wilstrand *et al.,* 2007) and hopelessness in their work with people who self-harm and are suicidal (Pompili *et al.,* 2005; Read and Noonan, 2018). Findings from this study agree and build on these to demonstrate the role of agentic avenues within the workplace to counter the feelings of powerlessness and hopelessness engendered by suicides and self-harm. The two avenues participants discussed were involvement in *frontline* clinical interventions that could be rapidly judged as effective and, involvement in *strategic* networks to influence at a policy or commissioning level. This section will briefly consider each of these modes.

i) Avenue one: healthcare interventions with measurable good outcomes

An avenue from the frontline of prison healthcare was delivering interventions, such as treating Hepatitis C, that created good, measurable, health-enhancing outcomes. Drew noted:

'Apart from Hep C where you actually do make an immediate measurable

difference […] I can't think of another disease that will kill you if you don't get it treated, but we can cure […] So, that gave me the immediate gratification that, helped me to manage... cause I must be traumatised. Everyone says I've got a swinging stone in my chest rather than a heart, but... (laughs) … er... and maybe that's, that's part of the macho culture […] it was a great way of recharging the batteries, because something had made a difference…'

Drew (C, former prison doctor; national manager, prison health)

Within the data excerpt the energising effect of making a quantifiable difference provides a counterpoint for the difficulty, trauma and frustration of working with suicide and self-harm and the enduring impacts of that on the practitioner. The rapid feedback loop of good outcomes in working with those with Hepatitis C, alleviated some of the heaviness, but the possibility of suicide remained. Drew continued:

'… and some of those patients went on and died or killed themselves after we spent £10,000 curing their Hepatitis C.'

Drew (C, former prison doctor; national manager, prison health)

The precariousness of prisoner life is highlighted here. Even where the treatment and cure of disease is possible, the comorbidities of prisoner health in an impoverished prison estate, means curing a disease may not result in a life sustained. Other participants reported finding balance in their role from discrete, controllable clinical tasks, such as administering injections.

'So very quickly I was trained up to administer intramuscular injections. And so, I was doing that on a daily basis during COVID, which I really enjoyed. Going around different blocks and then on the back of that, then I started doing the Hep B vaccines, […] so I did quite enjoy it, but then obviously then you have that struggle of fighting prison regime... in terms of trying to get bodies into the healthcare department.'

Jude (A, former healthcare support worker)

As with Drew's data excerpts above, Jude's positivity quickly segued into the difficulties - the tension of delivering healthcare in custodial environments along with the frustrations of being unable to get prisoners into the healthcare department. It is a finding of this study that being able to choose and follow a course of action or task with tangible good outcomes for prisoners, helped sustain staff. This avenue balanced and diluted feelings of powerlessness and hopelessness arising from working with prisoner suicides and self-harm.

ii) Avenue two: involvement with strategic decision-making

The other main avenue staff utilised was involvement with strategic decision-making in national networks. This enabled staff to shift perspective away from the daily demands of frontline prison healthcare work, providing a chance for reflection, as well as influencing future policy and commissioning. Being able to influence at a policy level made the realities of the quotidian strains easier to bear.

> *'I've really wanted to see if – strategically - I can make a difference. […] So, where the clinical day to day stuff has been an experience of chaos, dysfunction, toxicity, then there's been this sort of how can we make a bigger picture difference? […] being part of the Covid clinical set and having lots of conversations with HMPPS partners, Health and Justice NHS England partners […] it's really been that strategic stuff and I've been thoroughly enjoying working with the commissioner […] So lots of things keep me in it, despite the really, the challenge of the day to day.'*
>
> Lee, (B, senior prison health expert and prison doctor)

Although working at a strategic level did not provide such a rapid feedback loop, it offered a shift in perspective, an increase in feelings of agency due to proximity to power, for example, a stronger relationship with the commissioner. Strategic involvement was another avenue to making a difference and a break from the 'chaos, dysfunction, toxicity' (Lee, as above). Another way to pause and shift perspective was the suggestion of job rotation. That is, that staff may work for a period, e.g. six months, in prison healthcare and a period in another setting before then coming back to the same or similar role, in the same prison. This could allow for the specialism and specificity of prison healthcare but with scheduled breaks to

allow a possible window of recovery for staff and a reorientation to prevent normalising attitudes sliding into desensitisation and dehumanisation, as explored in chapter 6. Gurpreet commented,

> *'I think the pressures of the job are not sustainable sadly. But I think I think Probably the way we deal with it is we think about rotational posts. We think about career development or all that sort of stuff that keeps people going. Thinking about what joint flexible working thinking about... working across different areas, you know all those sorts of things.'*
> Gurpreet (C, senior national director, health and justice)

The description of the pressures of this work as 'not sustainable' is notable. Rotations could provide time away from the pressures of prison without people having to leave prison healthcare work altogether, providing a mechanism to shift perspective. Healthcare delivered in other settings may provide a greater range of agentic avenues with restorative benefits for practitioners. Rotations were also suggested to open prison work to a wider range of clinical staff, who may not otherwise consider or encounter prison healthcare. If agency, meaningful change for prisoners (patients) and therefore meaningful work, cannot be found in prison healthcare, staff paradoxically may only remain in prison healthcare by periods of time working away from it, in other healthcare settings. If HMPPS are unable to create better working conditions for staff soon, this finding supporting staff rotations may offer a way forward for structuring and commissioning of prison healthcare to enable better retention of staff and also, of their expertise whilst minimising burnout and dehumanisation.

Whilst having elements of the role or allied responsibilities that enable actors to see outcomes is sustaining, there are risks too. Staff finding comfort in roles where they are the agentic actor "doing" actions to a passive prisoner subject may reinforce unhelpful medical and prison hierarchies of power. As noted above, focusing on the good achieved to create meaning may be a protective factor and enable staff to stay in role, but it may also disable reflection and dampen attempts to improve. In gaining satisfaction from one part of work, the desire to see improvement and change in another – in this case in rates of prisoner suicides and self-harm – may be diminished. There may also be the temptation to disavow any agency in the

reduction of prisoner suicides and self-harm because these are far more multi-faceted and multi-scalar phenomena than preventing Hepatitis B, which can be achieved by administering a series of injections. Having part of work that had clearer good healthcare outcomes – the avenues – was sustaining for staff amidst the professional and existential uncertainty frequently created in prisons with high levels of suicide and self-harm. It aided retention and provided a positive focus for beleaguered prison healthcare staff.

8d) Collegial trusting

Staff spoke about being part of strong teams as sustaining them in their work: this is conceptualised here as *collegial trusting.* Previous studies show camaraderie is viewed as important for prison staff generally, helping staff to feel 'not alone in dealing with frustrating situations' and to provide a 'forum to blow off steam when they feel overwhelmed' (Lambert *et al.,* 2010: 1231). Officer staff who perceived 'more support' from colleagues experienced 'significantly less stress' (Steiner and Wooldredge, 2015: 810). Good peer relations were 'sometimes linked to better care for prisoners, where it facilitated communication about prisoners at risk, for example' (Liebling *et al.,* 2005: 174). Findings from this study agree and extend extant work to suggest explicit themes like camaraderie and good peer relations/teamwork in the data are underpinned by a deeper theme of collegial trusting. Collegial trusting has significance for staff but also, as highlighted by Liebling *et al.* (2005), also for improved outcomes for the prisoners in their care. Although trust is divergently defined, a multidisciplinary review concluded that all conceptualisations of trust required 'confident expectations' and 'a willingness to be vulnerable […] under conditions of risk and interdependence' (Rousseau *et al.,* 1998: 395). More recent theorisations of trust have highlighted its processual nature, as 'a continually constituted […] relational process' (Frederiksen, 2014: 168), a process of becoming, 'forming and reforming', 'continuous and dynamic in the most fundamental sense' (Möllering, 2013: 289). To reflect this, this thesis uses the present continuous form of "to trust": trusting. There is a dearth of research on forms of trusting among correctional staff (Lambert *et al.,* 2020), yet workplace trusting 'engenders cooperation, improves communication, and facilitates effective use of resources' (Wheatcroft et al., 2012: 390). In a study of correctional workers, Lambert and colleagues identified two

main types of organisational trust: supervisory - the worker's relationship with their direct manager, and managerial - the worker's relationship with the managing organisation (Lambert *et al.,* 2012). The two genres of trusting explored in relation to burnout unhelpfully replicate hierarchical prison dynamics, the quantitative methodology does not enable insights into how prison staff experience these forms of trust, nor does the study consider the significance (or otherwise) of trusting *between* workers. This thesis proposes a third key element of organisational trusting, a horizontal element – that of collective or *collegial* trusting. Collegial trusting is generative and is defined as the confident expectation that your colleague will support you in your work when needed, including under conditions of risk. Previous scholarship considers the importance of prison officer staff solidarity, which can be 'a resource and protection' for staff (Peacock *et al.,* 2018: 11). This chapter builds on the work of Peacock *et al.* (2018) preferring the dynamic active verb of "trusting", to demonstrate how the collective enterprise of collegial trusting can be protective and restorative for prison healthcare staff working with prisoner suicide and self-harm. Increasing workplace trusting between staff holds potential for improved outcomes for staff and prisoners and the section concludes with suggestions for fostering it.

8d.i) Frontline experiences of collegial trusting

Data from former frontline staff contained explicit references to camaraderie and teamwork, underpinned by collegial trusting. Participants then linked this to reduced feelings of stress. This sense of trusting between colleagues was protective and restorative in work that can induce anger and antipathy in staff (Hewson, 2022), damaging relationships with prisoners, leading to poorer outcomes for prisoners (Marzano *et al.,* 2013). This contrasted with less positive comments about supervisory (direct manager) or managerial (organisational) trusting. Participants in this study used the word camaraderie to highlight times of working closely together under extremely difficult circumstances, emphasising the importance of other people in being effective in their work. Hayden and Sullivan explained:

> *'… there's a lot of bonhomie and camaraderie as well, and it was dark, literally, but particularly as time wore on… I think, basically, being always short staffed, it's like a lot of places when you're working in a tight knit group, it did feel like good teamwork, and we had a reasonably good thing going on considering*

the resources […] good teamwork here, sort of backs against the wall style working sometimes, sometimes literally.'
Hayden (A, former prison nurse/healthcare officer)

'And the sense of camaraderie and teamwork between a lot of the staff […] and that was a real, like, bonus of the job.'
Sullivan (A, former frontline VCS healthcare worker)

Other studies note the risk of camaraderie being a cover for inappropriate "banter" and exclusive humour (Barry, 2017 and 2020; Liebling *et al.,* 2005): this was not a finding in this study. Given the current issues with prison healthcare staff recruitment and retention (Goddard *et al.,* 2019), further research is needed to understand how available staff feel camaraderie is to them with high vacancy rates and regular use of agency staff. Camaraderie, underpinned by collegial trusting, had often developed over time or because of time away from healthcare delivery spent together as colleagues, able to connect with each other. Once again, the fast pace of prison healthcare work identified in chapter 4c, sets challenging context within which to develop camaraderie as part of relationships that are collegially trusting.

Participants gave practical examples of teamwork in interventions to suicidal and self-harming prisoners, made possible by high levels of trusting between colleagues. Participants spoke about colleagues stepping in when they became overwhelmed. Hayden spoke about treating wounds after a prisoner had self-harmed:

'… it was pretty, pretty difficult […] sometimes you just got kind of stymied by the situation, so, you bounce up, you do your medical bit and forms need filling out and dress it, and then sit with the patient. And - a couple of times - I can remember just being a bit lost for words and someone else taking over. There's no explanation for it, […] just occasionally, I wasn't as bang on it as I, as I always, always was sort of thing […] you see that in other people as well. Normally people click into gear, go through the motions, do the drill and then, yeah, sometimes you have to take over from people and just give them a rest really.'

Hayden (A, former prison nurse/healthcare officer)

Staff overwhelmed by the acuity or sustained acuity over time of working with self-harm, needing 'a rest' (Hayden, as above), were reliant on trusted team members noting what was happening to their colleague who was treating someone and stepping in. Staff who trusted each other, working as a collective to address prisoner healthcare needs resulted in continuation of care for the prisoner. Other instances of teamwork, underpinned by collegial trusting in the data, preserved life. Ashley recalled,

> *'I do remember having to give someone CPR after one particular ligature on that unit. It's just so stressful with that... in a very different way to the later years. But there was such, I felt so supported by the officers, not necessarily by the nursing staff actually that I had at the time, but the officers were just amazing […] We moved her off the bed onto the floor. She wasn't breathing. You know there was no breath coming and an officer did mouth to mouth and I did the chest compressions […] I never felt particularly stressed out by that. I think because of the camaraderie on the unit and I think we were all in it together, and […] the fact she came back and she was fine and she didn't tie a ligature for a few days after that. Then she did.'*
>
> Ashley (A, former RMN and senior healthcare manager)

The support and trusting between, unusually, officers and healthcare staff was crucial in the resuscitating the prisoner. The sense of collectivity from collegial trusting and the successful preservation of life, reduced stress and sustained staff in their work. It is notable that both these data excerpts are from participants who left prison work almost a decade or more ago and that given the findings in chapter 4 around pressure, paucity and pace, further research is needed on current staff experiences of collegial trusting. In profoundly challenging work with prisoner suicide and self-harm, colleague relationships built on trusting, sustained staff and aided the delivery of, at times life-saving, healthcare for staff and prisoners.

8d.ii) Fostering collegial trusting: time

Data contained suggestions for how to foster collegial trusting in the challenging prison environment, though these were often predicated on some degree of staff continuity and time, both of which can be scarce. Collegial trusting is catalysed by shared goals, expressions of kindness and staff spending time together in work but outside the moment of healthcare delivery. Regardless of professional specialism, a common goal, aided trusting and motivation for the achievement of those aims.

> *'I think there was a real team spirit and the wish to help women improve their lives. And I think that came from multiple agencies […] I think overarchingly, we all had the same wish for that, but we came at it from different angles.'*
> Jean (A, former prison psychiatrist)

Participants reflected on the function of collegial trusting in prison. Ashley gave this advice to current prison healthcare staff working with suicide and self-harm:

> *'Look after each other. That's the key, it's that. Take care of one another. Because you can't do it on your own. You have to talk about it. You have to, if you're feeling pissed off, you've gotta have somewhere to say that […] in the community perhaps you would have a caseload of your own patients - you can't be like that in prison. Everyone's got to kind of know everything and you've got to work as a team. And that goes for information, but it also goes for supporting one another.'*
> Ashley (A, former RMN and senior healthcare manager)

Data highlighted the importance of good relationships, compassion, of collegial trusting, to both delivering healthcare and being part of a collective that enabled staying sane and safe as a practitioner. The data excerpt above emphasises the importance of staff being able to stop the surface acting that professionalism requires when with prisoner(patients) and having colleagues you can demonstrate a wider range of feelings to, e.g. being 'pissed off' (Ashley). This enables functionality, it also is crucial in retaining sentience and reducing the likelihood

of dehumanisation. Bobby and Fin offered this advice to current staff working with prisoner suicide and self-harm:

> *'Have lunch together. Spend time with each other. Build relationships with your colleagues. You can't do it all, and you're not a failure. People will kill themselves and harm themselves in prison and out of prison. And what saves people, in the end, are relationships.'*
> Bobby (A, former prison psychotherapist)

> *'It's not about what you know, it's about knowing who you can go to, to get the response that you need, and it's about knowing who you can pick up the phone to and say, "do you know what? I just need five minutes or can I come and see you? I need a cup of tea", or whatever.'*
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

Data contained many examples of the primacy of trusting staff relationships, which usually required time to build, in sustaining staff through difficult experiences and days at work that threatened to overwhelm them. In a system which is under-staffed and over capacity (Prison Reform Trust, 2024), with such high levels of suicide and self-harm (Ministry of Justice, 2024a), the conundrum of how staff can develop trusting relationships with each other is profound.

8e) Talking and being witnessed

The final theme in this chapter is staff talking about their experiences and this being witnessed by others. Being witnessed is defined as having experiences listened to, acknowledged and any feelings or responses to those experiences acknowledged, as a practitioner and as a human being. Prisons are surveillance institutions, staff therefore may be used to being watched for purposes of prison order and security but not necessarily seen or heard, in terms of their own *lived experiences*, the *knowledge* gained from them and impacts of these. The hierarchical nature of penal power renders some narratives more valuable than others

(Maruna, 2001) and creates a restricted epistemology of prisons. Bearing witness to those with lived experience of prison - both the incarcerated (Buck, Tomczak, Harriott, Page, Bradley, Nash and Wainwright, 2023), and those working there – expands this epistemology. The crucial element in data from this study was that as staff talked, their words were acknowledged and responded to by another person: this was essential to retaining their own sense of humanity. The importance of witnessing the witness to reduce the potential occurrence of trauma in other workplaces, e.g. police viewing sexual offending materials, is noted (Parkes, *et al.,* 2019). Previous prison studies have identified the importance of talking to colleagues (Whitter, 2021), the role of clinical supervision (Walsh, 2009) and the role of reflective practice (Freshwater, 2005), e.g. the *modes* of witnessing, explored further in 8e.ii of this chapter. Building on this, the novel finding here was a common element of being witnessed. The connection and co-production of witnessing builds collegial trusting and understanding, it expands epistemology and alleviates hermeneutical marginalisation, it could be restorative and sustain prison healthcare workers. This final pocket of hope considers why witnessing is so important, how it happens in busy prisons – the modes of witnessing and the challenges to talking and witnessing in prison healthcare work.

8e.i) Why witnessing matters

In a prison system that pursues the individualisation of responsibility (Garland, 1996), the connection with another person who witnesses the words spoken and then to become 'responsible in some way to it' can be a powerful tool of resistance (Peters, 2001: 708). It is predicated on another person's presence, indeed 'the listener is part of the creation of the knowledge […] facilitating the very possibility of testimony' (Guerin and Hallas, 2007: 11). The words "to witness" have an 'inherent relationality… Witnesses, after all, always bear witness to some*thing*; they testify to some*body*' (Richardson and Schankweiler, 2019: 168, emphasis in original). Being witnessed by another person also enabled a degree of separation from the events relayed, 'the listener becomes a witness to the witness… sharing its burden' (Guerin and Hallas, 2007: 11). This opportunity to share the burdensomeness, and to separate, from the things encountered in prison healthcare work sustained those workers.

Being witnessed also helped tackle prison healthcare staff feelings of loneliness and isolation. Prison healthcare staff can feel isolated in their role, e.g. being the only GP in the prison. They

also experience being misunderstood within the wider prison staff group because of their anomalous status as healthcare professionals within the prison system, an example of 'hermeneutical marginalisation' (Fricker, 2018: 53). Hermeneutical marginalisation is an outworking of 'structural injustice', an experience that can be ameliorated by one person listening to another but where the hearer may struggle to understand because they lack 'sufficiently shared concepts'; yet, 'the more actively a hearer listens, the more the speaker's hermeneutical marginalisation is thereby eroded', contributing to the 'shared hermeneutical resource' (Fricker, 2018: 54-55). The structural reasons that cause the hermeneutical marginalisation of prison healthcare staff (and, more urgently prisoners), still require action and, witnessing helps erode marginalisation by sharing experiences more widely. Morgan noted:

> *'… there's so few people that work in those environments, it's not like you've got a huge hospital full of staff where you can talk about different experiences and people have often may not have worked in the same speciality, but that's the underpinning principles of - ohh, well, I can understand why that might have happened. Prison work is so completely different. It's an anomaly really, and there isn't really anybody that you can talk to outside of that. Unless you're in it, you don't really appreciate and understand what's happening and how it feels to work in that environment.'*
>
> Morgan (A, former RGN)

Prison healthcare practitioners could acknowledge, with colleagues, that they were 'witness to a reality as it is rather than as she[they] pretended it to be' (Popescu, 2018: 316). Being able to share candidly with colleagues and have experiences and feelings affirmed as valid, rather than just minimising potentially traumatic events as "normal" (see chapter 6.a.ii), reduced feelings of isolation, eroding their hermeneutical marginalisation and potentially enabling their validated experiences to be shared more widely. As participants in this study described what they witnessed, the interviewer bore witness to their experiences and accounts of witnessing in prison healthcare roles, affording participants' words time, space and value. In a workplace with many policies and procedures to be followed, a workplace that

is literally and metaphorically noisy, having another person listen to and validate experiences and/or resultant feelings, enabled staff to carry on.

8e.ii) Modes of witnessing

Prison healthcare staff discussed different modes of being listened to and having their experiences acknowledged. Extant prison studies demonstrate the importance of talking to colleagues (Whitter, 2021), the role of clinical supervision (Walsh, 2009) and the role of reflective practice (Freshwater, 2005). This section brings on this work to highlight the range of modes for witnessing and that it can be a small act, minute and everyday. Being witnessed sustained staff in this work over long careers, be that by supervision, personal therapy, familial or collegial support. Bobby noted:

> *'It's not just the day job and you think about these people all the time. But you need to think about it in a structure with support, and the supervision, and the therapy, and spending time with colleagues - all supported and made it possible for me to do that, because in the beginning when I started, I would come home and I wouldn't be able to sleep. And the things that I've heard... I wish I could unhear them […] I don't think I could have done this work, this intensive work for 25 years without that, I'm sure of it.'*
>
> Bobby (A, former prison psychotherapist)

Finding and establishing spaces to be witnessed, enabled staff to feel supported in their work. Structured support was more easily accessible to some genres of healthcare workers, e.g. psychotherapists, and was less available to and less accessed by others, e.g. registered general nurses. Participants highlighted the lack of structural support to process and be witnessed, and the random, dependent-on-an-individual nature of the opportunities to be witnessed.

> *'We used to do group work […] We had a really good consultant psychiatrist for a spell, a young, ambitious consultant - he was excellent. I loved working with him and he really, made us, we all kind of dragged each other along sort of thing. Encouraged, like I say, team working.'*

Hayden (A, former prison nurse/healthcare officer)

Being witnessed in supervision deepened collegial trusting and enabled team working. Structured spaces to speak out experiences were validating for staff and reinforced good working relationships, helping sustain prison healthcare staff.

Witnessing did not only occur in structured interventions, it could also be minute and everyday. Witnessing could happen with an immediate team member, former colleague or a person from wider professional networks. Staff being able to share what they had seen or heard, with honesty and without enhancement, helped with the processing and understanding of difficult and potentially traumatic experiences. Rumi explained:

> *'Around all of that, it's very, very important to debrief with colleagues. Just to share. Because sometimes you've heard the most appalling stuff and you need to park it somewhere... safe. And I'm an external processor, so simply for me to share it with another is enough.'*
> Rumi (A, former prison counsellor)

Fin also highlighted the importance of trusted people to share the detail of a difficult day with:

> *'But also, within our organisation, even an ad hoc informal conversation sometimes is helpful, and I've got a good network of people, not necessarily around me because I don't see some of them for months on end, but I do know there's people that I can get on the end of the phone to and say, "you know it's been rubbish here today". There are people that I can call and say, "you know it's been terrible".'*
> Fin (A, former RGN, Head of Healthcare, Regional Operations Manager)

The data excerpts above both rely on having another human being to share experiences with and are further examples of the role of *collegial trusting* and the importance of staff having *time* to speak about their experiences with another. Data contained examples of everyday

witnessing that was restorative and enabled staff to stay at work. Morgan recalled her experience following saving a prisoner's life:

> *'…it was a probably a couple of weeks later where I just started to think - that was really, that was a close call and it made me feel... a bit wobbly, really about things like clinical competence and what might have been different and how would I have reacted… and I had to really quite, I had to work to keep it all in context really because it, there was a danger that it would have all have spiralled out of control a little bit, but... I worked through that and I talked to somebody, talked to the nurse who had been with me at the time and it wasn't just me that felt like that, so that made it feel a little bit better.'*
> Morgan (A, former RGN)

These small moments of connection between colleagues that enabled witnessing, mattered. Being able to talk with a colleague, having feelings heard and understood, meant Morgan could reduce feeling 'a bit wobbly' and prevent their thoughts spiralling 'out of control' (Morgan, as above) following a life-saving intervention. This enabled Morgan to continue in their role in that shift and beyond. Witnessing gave participants a way to connect with their experiences and feelings, which as noted in chapter 6c was essential in preventing staff from becoming chronically detached and then dehumanised or dehumanising prisoners in their care. Witnessing could be provided by the institution or experienced as minute and everyday, what mattered was it happening and that it was sustaining and restorative for prison healthcare staff working with prisoner suicide and self-harm.

8e.iii) Challenges to witnessing

The key challenge to staff being able to be witnessed by others has been highlighted previously in this thesis, in chapter 4c, fast pace. Staff could not always able to be witnessed by others due to the pace of work. Other challenges, e.g. macho cultures preventing staff speaking honestly, were far less prevalent in data in this study. The dominance of managerial time over process time (Nellis, 2002) meant that staff working with prisoner suicide and self-harm did not have time to process what had happened and how they had responded to it, before needing to attend to other prisoners in their care. Staff living with the aftermath of

difficult experiences may not be easily visible, leading to a lack of ongoing acknowledgement and care in the following weeks.

> *'… because of the fast-paced environment, I think there's a tendency to just encourage staff to deal with things like that quickly and then just move on and carry on in their day to day. But in reality a loss like that, it's going to impact people in different ways […] And yeah, allowing time afterwards, not necessarily just a week or two weeks, these things might come and go in terms of their impact on someone, so allowing flexibility with that.'*
> Sammy (A, former prison psychologist)

Finding ways to allow for pauses in the working day where staff can create times and spaces for moments of connection and witness, not just in the immediate aftermath of crisis, could better support staff working with prisoner suicide and self-harm. This is incredibly challenging in current prison circumstances. When this can happen, it is powerful and sustaining but too often, finding the time to describe what has happened and how that felt can seem impossible to staff. Morgan recalled:

> *Interviewer: 'What kind of support did you receive at the time for either of those incidents?'*
> *Participant: 'Nothing. Pick up, pick up the rubbish, chuck it in the bin, get on with the next bit of your job. Yeah […] I think it would have been nice to have had time to... if the person who'd done it to themselves was in a position where they wanted to talk, would just be to talk about are you feeling OK? What can I do to help you at this point? […] I think that's where the two regimes really clashed […] the prison regime is like, we can't do any of that because we've got a job to do.'*
> Morgan (A, former RGN)

The healthcare worker was unsupported and also felt unable to support the prisoner as they would have liked to, following an incident of self-harm. The primacy of the prison setting

compromised the care provided, leaving no time or space for further interaction with the prisoner, nor time or space to have their experiences witnessed by another.

Witnessing mattered for staff, it provides an example of an accessible, everyday tool that recognised the humanity of healthcare staff and contributed to stemming the flow of dehumanisation and identification of staff as units of productivity. It could disrupt the process of staff responses to prisoner suicide and self-harm, altering outcomes. For example, having a colleague witness a two minute anecdote about a difficult experience of prisoner self-harm, helped the practitioner realise it had upset them and that they needed to take further action; this then avoided the incident that day contributing to disenfranchised trauma. Witnessing could erode hermeneutical marginalisation, reducing the likelihood of staff isolation, siege mentality and burnout. It could enable the naming of painful, harmful experiences, contributing to reduction of risk of disenfranchised grief and (disenfranchised) trauma and increase awareness in the listener of these experiences of prisoner suicides and self-harm, helping to recalibrate the listener's views. Witnessing enabled prison healthcare staff to stay connected to and demonstrate compassion in their practice with prisoners(patients), operating less punitively. The lack of opportunity to be witnessed can mean staff are silenced, leading to an absence of knowledge of those frontline staffs' experiences of prisoner suicide and self-harm, limiting epistemology and/or creating an epistemological inequity (Booth and Harriott, 2021). This can happen concurrently with the privileging of official narratives from the HMPPS and/or prison healthcare providers, that may conflict with staff, as well as prisoner, accounts. It was a tool that also held significance for the future prisoners(patients) and the way in which prison healthcare staff were able to respond to the next prisoners' needs, manifesting through self-harm and/or suicide attempts. Witnessing can alleviate the immediate, enduring and cumulative impacts of working with prisoner suicide and self-harm, referenced in the research questions. It is no "silver bullet", especially given the current context, but can interrupt trajectories of pain and trauma and is a pocket of hope that may be more widely utilised.

Conclusion

This chapter explored the cohort of staff who sustained themselves in an exceptionally tough workplace and, at least *some* of the time delivered compassionate healthcare to prisoners

who self-harmed and/or were suicidal. It provides insights to subquestions b and c of the research questions, illuminating how staff manage the enduring and cumulative effects on themselves of working with prison self-harm. It is also included for its ontological saliency. Novel findings for this cohort of prison healthcare staff were that although undeniably squeezed by prison conditions, they still retained connection to their emotions and internal world. Staff demonstrated humanity, compassion and curiosity. Staff sustained themselves by taking action within prison healthcare to improve other health outcomes, to dilute their chaotic and unpredictable work with prisoner suicide and self-harm. Most commonly this took the form of involvement in frontline clinical interventions that could be rapidly judged as effective and, involvement in strategic networks to influence at a policy or commissioning level. Collegial trusting was newly conceptualised as underpinning explicit themes in data like camaraderie and good peer relations/teamwork, expanding extant studies. The collective enterprise of collegial trusting can be protective and restorative for prison healthcare staff working with prisoner suicide and self-harm yet it is requires time to build and is challenging to foster it in current prison conditions. The final findings here are concerned with talking and being witnessed. These mattered in disrupting the "inevitability" of staff responses to prisoner suicide and self-harm; those responses *are* mutable and how staff respond can alter outcomes for those in their care. Witnessing can erode hermeneutical marginalisation, thereby, in a small way, diminishing epistemic injustice. Witnessing can alleviate both the enduring and cumulative impacts of working with prisoner suicide and self-harm and could be more widely deployed to interrupt staff sliding down the acclimatisation continuum with poorer outcomes for all. These original findings – the pockets of hope – are generative and can interrupt the processes and stories of struggling staff, which may then positively impact staff's ability to work well with prisoners who are suicidal and self-harming. The next chapter draws the thesis to its conclusions.

Chapter 9: Conclusions

Introduction

This thesis has answered its core research question by exploring the experiences of prison healthcare staff working with prisoner suicide and self-harm in 21st century prisons in England and Wales. The supplementary research questions highlighted temporality, looking to identify the initial impacts on staff, as well as the enduring impacts on them and, how their cumulative exposure to prisoner suicide and self-harm affected them, their practice and the prisoners in their care. Participants repeatedly returned to the constrained context – custodial, underfunded, under resourced – in which their work with prisoner suicide and self-harm occurred and the implications of this for them, their practice and the prisoners in their care. Findings, in their basic form, regarding initial impacts on staff supported extant literature. For example, working with prisoner self-harm highlighted the tension between care and custody, repetitive self-harm was especially challenging for staff to work with; after prisoner suicides, staff experienced sadness and guilt. Data also brought along existing knowledge by understanding normalisation, detachment, desensitisation and dehumanisation as part of an acclimatisation spectrum, that is dynamic and intervenable in. Novel findings in this thesis chiefly arose from the enduring and cumulative impacts on staff – providing an answer to research subquestions b) and c), such as the damage caused by staff attendance at coroners' courts and the further consequences of this for future prisoners who were suicidal and self-harming in their care. Given this thesis' processual ontological approach, chapter 8 Pockets of Hope, was also included to highlight everyday motivations and practices of staff that interrupted deathly determinism and demonstrated how humanity can be found and nurtured, even in prisons. Small, quotidian actions, e.g. witnessing, could build trusting and generated hope, enabling staff to conceive of different ways of being and doing, then enacting that with the next suicidal or self-harming prisoner they worked with.

The other notable element to highlight here was that the temporal and practice-based interval between staff experiences and the data collection was more significant than could have been envisaged in enabling a nuanced, reflective dataset. Viewed from a different perspective than that inhabited whilst still working inside prisons, participants rendered that which had

become invisiblised as normal whilst they worked in prisons, e.g. high levels of prisoner self-harm, as *visible* again. This interval generated multi-layered data as staff recalled perceptions, feelings and responses both *at the time* and how they viewed them *now*, creating thick descriptions and reinforcing the dynamic, contingent nature of knowledge. This facilitated nuanced insights that would have been less likely in the original study design. From the emergency of Covid-19 and the constraints this placed on the world and this study, emerged the new idea of interviewing former staff. This was a great benefit to the study and the analysis enabled. This conclusions chapter will revisit each chapter's findings and analysis, highlighting how these lived experience voices expand prison epistemology and champion the collective nature of preventing prisoner suicide and self-harm. Ultimately hoping to contribute to, in however small a way, to safer, less deathly prisons.

9a) Chapter findings and analysis

9a.i) Chapter 4 findings and analysis

Chapter 4 built on the Introduction to consider how the current prison permacrisis affected work with prisoner self-harm. Prisons are part of an overloaded justice system, struggling to meet the needs of those within it. Prison healthcare staff experiences of prisoner self-harm in this context included: under-reporting of self-harm that was greater in volume and in severity than in analogous settings. The chapter conceptualised invited violence, demonstrating broader definitions of self-harm are needed to encompass the range of ways prisoners may harm themselves, e.g. starting fights. Extending scholarship that identified clinical, psychosocial and environmental factors (Favril *et al.,* 2020), the chapter attended to and made explicit the governmental factors that were contributory to staff responses to prisoner self-harm. Deteriorating prison environments (Ismail, 2023) stifled therapeutic attempts to work with self-harm and contributed to its prevalence, which could make self-harm seem an inescapable outcome. Healthcare staff experienced the coercive isomorphism of the prison system, reducing their temporal capital and an ever-quickening work pace. Staff were required to work in managerial time and were less able to attend to their own needs, feelings and reality. The pressures, paucity and pace of contemporary prison healthcare meant self-harm could become viewed as a demand to be managed like any other rather than as an unmet need that is complex, requiring process time, care and attention. Healthcare staff so

constrained by the prison, low staffing levels and the fast pace, experienced distress and, in some cases, moral injury where they were unable to deliver healthcare as they wanted to. This then contributed to neglectful and iatrogenic consequences for prisoners who self-harmed. Institutionally, whilst staff support staff may have increased (Marzano and Adler, 2007), prisons still normalise and minimise the distressing nature of working with self-harm, putting the onus on the individual staff member to access interventions, further responsibilising them. Prison healthcare staff working at a fast pace, disconnected from their own emotional worlds, without space and time to recognise the impacts of working with self-harm, could also experience disenfranchised trauma. Particularly where staff had experienced multiple incidents of self-harm over time, the erosion caused by this cumulative exposure often went unheeded, leaving staff to struggle. The institutional minimising of self-harm silenced healthcare worker experiences – something staff themselves may contribute to, restricting prison epistemology. The distance from frontline prison healthcare, by time or role, enabled these novel contributions as staff were more able to reflect about the effects this work had on them as compared to when they worked on the frontline.

9a.ii) Chapter 5 findings and analysis

This chapter demonstrated the experiences of those working in prison healthcare with suicidal prisoners was profoundly influenced by the underfunding and under resourcing of prisons and prison healthcare: the outworkings of systemic and governmental factors undergirded this chapter's findings *too*. Systemic and governmental factors have practical, and in some cases fatal, consequences for healthcare staff working with suicidal prisoners. Prison healthcare staff often carried on working despite their distress following prisoner suicide, noting that more violent and visceral methods of suicide were a potential indicator for trauma. Even where lives were saved, staff could experience enduring anxiety and questioned their competency, especially when poorly supported. Staff cited enduring effects from being unable to treat the body with dignity after death, it traversed a professional boundary, evoking moral injury and a lack of resolution that troubled staff: these are original contributions to knowledge. How staff were informed about a death also mattered and, done poorly, dehumanised, isolated and exacerbated the distress of staff. The pressures, paucity and pace of prison healthcare work, contributed to by governmental factors were relevant again here, therefore, this chapter argued that some prison suicides would be more appropriately

identified as 'induced self-violence' (Aitchison, 2024: 905). This nomenclature renders a range of contributory factors more visible, including factors outside the suicidal prisoner or the healthcare worker. These resourcing pressures constrained prison healthcare staff's ability to undertake ACCT processes as intended and their professional curiosity was stymied. This resulted in negative outcomes for those in their care and created enduring questions for staff about their own judgement and competency, even though many acknowledged the systemic nature of the challenges in keeping prisoners alive. When prisoners completed suicide following the identification of known risk factors, staff experienced despair. Prison healthcare staff viewed most prison suicides as potentially preventable, which created enduring sadness. The possible preventability of suicides was simultaneously depressing – with regards to the persistently high numbers of prisoner suicides despite their possible preventability (Ministry of Justice, 2024a); and deeply hopeful – there are always possibilities, things that can be done differently that may yet preserve life.

9a.iii) Chapter 6 findings and analysis

Prison healthcare staff acclimatised as they worked with suicide and self-harm in the prison environment: this thesis conceptualised this as an acclimatisation continuum. The continuum had strategies for retaining staff human-ness at one end, through phenomena more prevalent in the data of normalisation, detachment, desensitisation and dehumanisation. Practitioners were working in broken institutions with a lack of accessible mental health care and inadequate tools to reduce self-harm and/or tackle the deeper causes, so normalising self-harm was commonplace and an easily accessible coping strategy for staff. Normalisation and detachment could have the consequences of desensitisation and dehumanisation, which were damaging for staff, prisoners and the prison ecology. This thesis created novel conceptions of detachment as temporary, chronic and/or acute to enable a deeper understanding of detachment and its utility in demanding workplaces. Staff struggled to detach *temporarily* then reconnect to wider emotions resulting in chronic detachment. This could lead to desensitisation and dehumanisation. Desensitisation had implications for staff practice and data demonstrated staff were less responsive and complacent, and, in some cases, evidenced examples of malignant alienation. Additional to potentially dehumanising prisoners, prison healthcare staff could become dehumanised: this is a contribution to knowledge. Prison healthcare staff were alienated from themselves and others, with collective prison pressures

dehumanising staff who may then unwittingly pass this on to those in their care. This could create further harms and inhumane prisons, despite staff's desire and efforts to offer compassion and hope in individual cases. The mental gymnastics required when working in the damaging institution of prison, produced the coping strategies of normalising self-harm and detachment from internal worlds. This diminished the hope of recovery, the idea that things could be different, making it harder for staff to hold that possibility in mind and negatively influencing the care provided. However, the acclimatisation continuum is dynamic, the insidious slide into dehumanisation was not inevitable, it was interruptible.

9a.iv) Chapter 7 findings and analysis

Prison healthcare staff testifying to coroners' courts could be enduringly impacted by their experiences: these experiences then had consequences for practice. The findings in this chapter were unexpected, it was not anticipated that experiences from coroners' courts would be so salient to the lives of participants nor that it would generate a whole chapter of novel findings and analysis. This chapter demonstrated that coroners' court attendance is stressful, anxiety provoking and distressing for a wider staff cohort than just those called to the inquest. Preparation and support ahead of coronial inquests offer mild mitigation. The salience of temporality recurred, be that the elongated time frames experienced waiting for coroner's inquest which could embed enduring difficulties for staff or staff acting in the present from fears of an anticipated future. The reach of coercive isomorphism of the coroner's court into prison healthcare, coupled with responsibilisation, was significant. Delays, difficulties and deflection compounded what were already tough experiences for staff, affecting the individual, their colleagues, their practice and with further implications for prisoners in their care. Delays highlighted the precarity of prison healthcare staff's temporal capital and led to staff querying the efficacy of coroners' courts and their ability to reduce prison suicides. Staff experienced considerable difficulties at coroners' courts due to inquest juries' lack of knowledge of prisons. Visible prison healthcare staff became cyphers for scrutiny within coroners' courts, deflecting scrutiny from the policies that create the systems the staff and institutions operate within. Low confidence, anxiety and avoidant strategies associated with attendance at coroners' courts created harms for the healthcare practitioner and those in their care. These distressing and sometimes traumatic experiences at inquests often created enduring distress and had a deleterious effect on staff retention. Further exploration using

processual ontological lenses, working across scales, may help to better understand and untangle the vicious circles of harms created in coronial courts, identifying moments for intervention for staff and potentially aid the alleviation of future suicides in prisons.

9a.v) Chapter 8 findings and analysis

The Pockets of Hope chapter explored the cohort of staff – the majority in this study – who sustained themselves in an exceptionally tough workplace and, at least *some* of the time delivered compassionate healthcare to prisoners who self-harmed and/or were suicidal. These were unexpected findings from inductive data analysis and created innovative contributions to knowledge. The strategies and acts that sustained staff are read in the context of the preceding chapters that chronicle staff's moral injury, disenfranchised trauma, dehumanisation, despair and more, with poorer outcomes for prisoners in their care. The inclusion of this chapter was ontologically important, emphasising the emergent nature of processual ontologies, highlighting the hope and potential for change and illuminating good practice. Finding meaning in their work sustained staff. This cohort of prison healthcare staff were undeniably squeezed by prison conditions, but still retained connectedness to their emotions and internal world. Staff demonstrated humanity, compassion and curiosity. Staff sustained themselves by taking action within prison healthcare to improve other health outcomes, to dilute their chaotic and unpredictable work with prisoner suicide and self-harm. Staff chiefly did this in two ways: frontline clinical interventions with easy to measure, rapid outcomes and by involvement in strategic networks to influence at a policy or commissioning level. Also of import was collegial trusting, which underpinned explicit themes in data like camaraderie and good peer relations/teamwork, expanding extant studies. The collective enterprise of collegial trusting can be protective and restorative for prison healthcare staff working with prisoner suicide and self-harm, yet it requires time to build and is challenging to foster it in current prison conditions. The final Concluding contributions to knowledge here highlight talking and being witnessed, these actions disrupted the "inevitability" of staff responses to prisoner suicide and self-harm, which could alter outcomes. Witnessing could erode hermeneutical marginalisation, thereby in a small way diminishing epistemic injustice. Witnessing can alleviate both the enduring and cumulative impacts of working with prisoner suicide and self-harm and could be more widely deployed to interrupt staff sliding down the acclimatisation continuum with poor outcomes for all. These findings – the pockets of hope –

are generative and can interrupt the processes and stories of struggling staff, which may then positively impact staff's ability to work well with prisoner's who are suicidal and self-harming.

9b) To notice, to make visible: expanding prison epistemology

Much of prison life is unseen by the outside world (Podmore, 2012), including prisons as places of work (Crawley and Crawley, 2008). This thesis demonstrated that many aspects of prison life go unseen, unnoticed or unheard within prisons too, contributing to worse outcomes for staff and prisoners. These things remain unnoticed not because prison healthcare staff are consistently cruel or careless, but because of the pace staff are going at, the pressure they are under and the lack of time and space to pause, reflect and then act. In chapter 4 this was most apparent in the experiences of disenfranchised trauma – trauma unnoticed within staff themselves because of its cumulative genesis. In chapter 5 staff lacked professional curiosity, unable to see or perhaps notice what is in front of them; even when what is in front of them is a person with a ligature standing on a chair, because they said "no" when asked if they were experiencing suicidal feelings. In chapter 6 staff's internal world, their deeper responses to suicide and self-harm, go unnoticed by themselves and by colleagues, as staff detachment becomes chronic. Not having time to notice, to observe in each instance cited here can then prevent staff from effective reduction of suicide and self-harm, contributing to further harms. As Ackerly (2024: 204) reminds us, 'Power and relationality are not themselves always visible. This may be why we often focus on harms rather than the causes of harms'. Throughout the thesis there is an attempt to notice the complex and contributory prison setting and to keep making visible systemic and governmental factors germane to analyses. Making visible and noticing the less frontline elements helps with understanding the multi-scalar contingencies evoked by staff experiences of prisoner suicides and self-harm and offers alternatives.

This thesis contributed to the noticing and analyses of the lived experiences of prison healthcare staff working with prisoner suicide and self-harm. Lived experience knowledge of prisoners, and for the purposes of this thesis - of staff, is often not prioritised or adhered to due to epistemological inequity (Booth and Harriott, 2021). These experiences can remain unheard, as the power of the dominant discourse renders 'some stories as tellable', whilst

excluding 'others as marginal and abnormal' (Foote and Frank, 1999: 177). Indeed, 'narratives that we find within criminal justice contexts are not just formed by and within a coercive disciplinary logos, but they have a functionality within those contexts' (Warr, 2022: 5). If the narratives of prison healthcare worker experiences go unspoken and unacknowledged *within* institutions, it seems unlikely they will be spoken and acknowledged *beyond* the justice system. A lack of noticing of lived experience stories of pain of trauma reinforces these experiences as untellable, marginal or irrelevant, invisibilising them and contributing to epistemic injustice. Silencing and/or an absence of language to describe these experiences hinder challenge to and interrogation of prisons with record rates of self-harm (Ministry of Justice, 2024a). Sheridan commented,

> *'I just used to go home at night and just not want to talk about it because... you know, it was just almost unbearable really […] it does make you feel very isolated, […] you just feel like - you see things clearly, but you're very on your own really, and so there is a really strong sense of solitude in that context.'*
> Sheridan (B, range of senior national health and justice roles, past and present)

The theme in chapter 8 of witnessing is relevant for scholars and staff to resist marginalisation and silencing, by noticing, hearing, seeing and then making experiences more visible. This may make a small contribution to the erosion of prison staff's hermeneutical marginalisation and perhaps, the erosion epistemic injustice. Indeed, 'by seeking to influence the murmurations of injustice […] we will be better able to take responsibility for the injustice itself' (Ackley, 2024: 204). Shift happens, however small. By noticing and making visible, people's experiences are rendered as valid and prison epistemology is expanded. Understanding the limits and possibilities of how staff sustain themselves working with prisoner suicide and self-harm, hopefully aids its reduction and the injustice of it.

9c) Achieving safer prisons?

9c.i) A collective task

Making prisons safer, for prisoners and staff, is a complex, urgent task. It is a fundamentally collective task, demonstrated in this thesis by the importance of collegial trusting and

witnessing in addressing the harms created by working with prisoner suicides and self-harm in such compromised prison settings. It requires continued resistance of atomisation and responsibilisation through making visible and highlighting the multi-scalar contributory factors: to suicides, as does Fitzpatrick (2016, 2018) and Aitchison's (2024) conceptualisation of induced self-violence, and Chandler's (2016) work on self-harm. Garland's body of work does similarly for prisons (Garland, 1990, 2001 and 2018), Ismail for prison healthcare (2019a, 2019b, 2020a and 2023) and Tomczak for prison suicide and its regulation (Tomczak, 2018, 2021, 2022a, 2022b and 2023). The depoliticisation of the debate about prisoner suicide has stifled ideas salient in the pursuit of safer prisons (Aitken, 2022). Although, whether prisons can ever be safe is contested territory (Sim, 2021; Steiner and Mead, 2014). Those keen on pursuing prison abolition cannot deny the urgent need for safety for the 85,000 or so people living, and all those working, in prison today. As repeatedly acknowledged throughout this thesis, in the summer of 2024 prisoner suicide and self-harm are at some of the highest recorded rates (Ministry of Justice, 2024a). Prison workers regularly experience physical and verbal assaults and threats, with staff shortages and high workloads impacting staff feelings of safety (McKendy *et al.,* 2021). Feelings of safety are engendered by being with other people who can calm your nervous system and enable you to feel safe (Porges, 2022). Given this, the findings herein suggest the path to safer prisons may feel long, but it is collective, involving other people and (f)actors: which means things can change.

The centrality of good relationships between prisoners and staff for their safety is well documented, regarding prevention of suicide (Liebling, 1992; Ludlow *et al*., 2015) and self-harm (Kalra *et al.*, 2016; Marzano *et al*., 2013; Short *et al*., 2009; Walker *et al.,* 2016). This thesis agrees and builds on this to highlight the importance of relationships between colleagues for prisoner and staff safety, specifically of collegial trusting and witnessing. Trusting relationships enable staff to shift on the acclimatisation continuum of chapter 6, for example, to reattach to a wider palette of emotions and keep detachment as a temporary phenomenon. Brown and Schept (2017) conceptualise safety as 'a product of structural transformation and is collective at its core… not simply about those who have harmed or been harmed, but a movement beyond disciplinary neoliberal frames of responsibilisation and internalisation to community and state accountability' (Brown and Schept, 2017: 449). It is this kind of safety which is invoked here and will be realised by inclusive, collective,

accountable actions. Collective definitions of safety, when applied to prisons may help to conceptualise accountability mechanisms that allow for the broad range of drivers and contingencies that diminish of prisoner safety and are contributory to suicide and self-harm. Experiences of coroners' courts could be made less punitive and damaging by these means, potentially aiding the retention of good staff, delivering compassionate healthcare. This collective path to safer prisons emerges as moment by moment, day by day, agentic actors even under incredible constraints, act. As here demonstrated: staff could remain tenacious in their actions to reduce prisoner suicides and self-harm over long prison health careers with positive implications for their colleagues and prisoners, e.g. halting the slide into dehumanisation highlighted in chapter 6. Many (f)actors may prompt change. The topographical nature of power is such that the road to safer prisons may *feel* long, but that long road, in a heartbeat, can change.

9c.ii) Investment in prevention

Participants in this thesis recognised the need for systemic changes, both inside and outside prisons, that could dramatically improve safety and reduce prisoner suicide and self-harm. As Bobby remarked:

> *'… suicide and self-harm is just a symptom of something. You don't fix that without, you know, it requires a structural difference. And people want to fiddle around once things get bad. I mean, prevention is better than cure, particularly if nobody's got a clue what the cure is. Prevent it!'*
> Bobby (A, former prison psychotherapist) [emphasis added]

The prevention of suicide and self-harm and the creation of safer prisons requires significant reductions in the prison population. That requires an agreement that an expedient way to deal with the damaging landscape of prisons is to have less people encounter it; be that via greater use of community sentences, better drug and alcohol services, improved mental health provision or by changes to legislation and/or the sentencing guidelines. At a time when surveillance technology flourishes, there is even less reason to persist in warehousing people in over-crowded, under-staffed Victorian prisons. Prisons have suffered from a long-term lack of resources and Ismail's (2023) work highlights how austerity policies have affected prison

healthcare. This thesis builds on extant work about the impacts of low officer numbers on prison safety (Liebling, 2011), by highlighting how the lack of resources and low staff numbers effects healthcare staff working with prisoner suicide and self-harm. For example, the implications of low contractual staff minimums in healthcare or self-harming prisoners in 4c.ii. The challenges to fostering of collegial trusting because of a lack of staff consistency due to low staff numbers and high agency staff use, compromise the quality of relationships and practice with prisoners and colleagues. The speed staff are going at matters to the effective prevention of suicide and self-harm, the 'timeframe employed matters because it impacts the construction of causality', rather than staff grasping at 'actions, moments, and fragments' to understand and make decisions about the next self-harming or suicidal prisoner in front of them (Carr and Maguire, 2022: 234). Therefore, staff who can pause – either for two minutes or two months – so they can acknowledge and recover from experiences, may be better able to notice, to see and to potentially reduce prisoner suicide and self-harm.

The subjects in this thesis are more usually correlated with despair and not hope and incorporates some troubling findings, it is ultimately a hopeful piece work. People, their thoughts and actions, can and do change themselves, and the people and things around them. Repeatedly. Whether by taking actions through in-work avenues to balance and dilute feelings of powerlessness and hopelessness arising from working with prisoner suicides and self-harm. Or, as they are listened to and witnessed by a colleague, acknowledging that they have seen things at work that day that affected them, preventing chronic emotional detachment and halting the slide into dehumanisation. Small, everyday actions. As Solnit (2004:13) reminds us, 'Inside the word *emergency* is *emerge*; from an emergency new things come forth'. Because in amongst the sadness, despair, multiple poor decisions and actions that have led to the prisons emergency, there are still people working collectively with compassion, humanity and hope, daily demonstrating another way *is* possible.

References

Ackerly, B. (2024) 'Murmurations of Injustice' in Browne, J. and McKeown, M. (eds.) *What is Structural Injustice?* Oxford: OUP. doi: 10.1093/oso/9780198892878.001.0001

Adshead, G. (1998) 'Psychiatric staff as attachment figures: Understanding management problems in psychiatric services in the light of attachment theory', *The British Journal of Psychiatry, 172* (1), 64-69. doi:10.1192/bjp.172.1.64

Aitchison, G. (2024) 'When Suicide Is Unjust Violence: Power, Structural Harms, and Moral Culpability', *Journal of Politics*, 86(3), pp. 905–919. https://doi.org/10.1086/729936.

Aitken, D. (2022) 'Investigating prison suicides: The politics of independent oversight', *Punishment & Society,* 24(3), 477-497. https://doi.org/10.1177/1462474521993002

Alexander, D.A. *et al.* (2000) 'Suicide by patients: Questionnaire study of its effect on consultant psychiatrists', *British Medical Journal*, 320(7249), pp. 1571–1574. https://doi.org/10.1136/bmj.320.7249.1571.

Amin, N. A. M., Yatin, S. F. M., Jali, J. M., Sahid, N. Z. and Abdullah, W. A. M. W. (2020) 'Making an Informed Decisions in a Teaching Hospital: How Medical Record System Helps', *International Journal of Academic Research in Business and Social Sciences*, 10(11), 549-564

Andriessen, K., Krysinska, K., Draper, B., Dudley, M. and Mitchell, P.B. (2018) 'Harmful or Helpful? A Systematic Review of How Those Bereaved Through Suicide Experience Research Participation', *Crisis*, 39(5), pp. 364–376. https://doi.org/10.1027/0227-5910/a000515.

Annison, H. and Guiney, T. (2023) *Locked In? Achieving penal change in the context of crisis and scandal: discussion paper with assistance from Zoë Rubenstein.* https://prisonreformtrust.org.uk/wp-content/uploads/2023/07/Locked-In_A-discussion-paper.pdf

Antai-Otong, D. (2001) 'Critical incident stress debriefing: A health promotion model for workplace violence', *Perspectives in Psychiatric Care*, 37(4), pp. 125–132. https://doi.org/10.1111/J.1744-6163.2001.TB00644.X.

Arnold H. (2012) 'The effects of prison work', in Liebling, A. and Maruna, S. (eds) *The Effects of Imprisonment*. Cullompton: Willan, pp. 391–420

Arnold, H. (2016) 'The Prison Officer', in Jewkes, Y., Bennett, J. and Crewe, B. (eds), *Handbook on Prisons* (2nd edition). Abingdon: Routledge, pp. 265–283.

Arnold, H. (2017) 'The psychological and emotional effects of prison on prison staff', *The Routledge International Handbook of Forensic Psychology in Secure Settings*, pp. 283–299. https://doi.org/10.4324/9781315673073.

Ashton, S. (2014) 'Researcher or nurse? Difficulties of undertaking semi-structured interviews on sensitive topics', *Nurse Researcher*, 22(1), pp. 27–31. https://doi.org/10.7748/nr.22.1.27.e1255.

Austen, L. (2016) 'Increasing emotional support for healthcare workers can rebalance clinical detachment and empathy', *British Journal of General Practice*, 66(648), pp. 376–377 doi: 10.3399/bjgp16X685957.

Auty, K.M. and Liebling, A. (2020) 'Exploring the Relationship between Prison Social Climate and Reoffending*', *Justice Quarterly*, 37(2), pp. 358–381. https://doi.org/10.1080/07418825.2018.1538421.

Auty, K. M. and Liebling, A. (2024) 'What is a "good enough" prison? An empirical analysis of key thresholds using prison moral quality data'. *European Journal of Criminology* 21 (5), pp. 725-753.

Awenat, Y., Peters, S., Shaw-Nunez, E., Gooding, P. and Haddock, G. (2017) 'Staff experiences and perceptions of working with in-patients who are suicidal', *The British Journal of Psychiatry*, 211(2), pp.103-108. https://doi.org/10.1192/BJP.BP.116.191817.

Bai, H., Bowering, S., Haber, J., Cohen, A. and Chang, D. (2021) 'From ego to eco: re-orienting for processual ontology in the "Dao-Field" '. *Cult Stud of Sci Educ* 16, 691–705. https://doi.org/10.1007/s11422-021-10028-w

Baker, D. (2016) *Critical Criminological Perspectives Deaths After Police Contact Constructing Accountability in the 21st Century*. London: Palgrave Macmillan.

Banwell-Moore, R. *et al.* (2022) '"The human toll": Highlighting the unacknowledged harms of prison suicide which radiate across stakeholder groups', *Incarceration*, 3((2)), pp. 1–20. https://doi.org/10.1177/26326663221097337.

Barry, C. (2017) '"You just get on with the job": Prison officers' experiences of deaths in custody in the Irish Prison Service', *Prison Service Journal*, 230, 53–60.

Barry, C. (2020) '"You can't tell anyone how you really feel": Exploring emotion management and performance among prison staff who have experienced the death of a prisoner', *International Journal of Law, Crime and Justice*, 61. https://doi.org/10.1016/j.ijlcj.2019.100364.

Becker, H.S. (2018) 'Labelling theory reconsidered' in *Deviance and social control* (pp. 41-66). London: Routledge.

Behnke, A., Rojas, R., Karrasch, S., Hitzler, M and Kolassa, I-T. (2019) 'Deconstructing traumatic mission experiences: Identifying critical incidents and their relevance for the mental and physical health among emergency medical service personnel', *Frontiers in Psychology*, 10, 2305.

Bell, C. M. and Khoury, C. (2011) 'Organizational de/humanization, deindividuation, anomie, and in/justice', in Gilliland, Steiner and Skarlicki (eds.), *Emerging perspectives on organizational justice and ethics* (pp. 167–197).

Bell, S., Hopkin, G. and Forrester, A. (2019) 'Exposure to Traumatic Events and the Experience of Burnout, Compassion Fatigue and Compassion Satisfaction among Prison Mental Health Staff: An Exploratory Survey', *Issues in Mental Health Nursing*, 40(4), 304–309 doi: 10.1080/01612840.2018.1534911.

Bennett, J. (2016) 'Prison Managerialism' in Jewkes, Y., Bennett, J. and Crewe, B. (eds.) *Handbook on Prisons* (2nd ed.). London: Routledge.

Bennett, J., Crewe, B., and Wahidin, A. (eds.) (2008). *Understanding Prison Staff*. London: Willan. https://doi.org/10.4324/9781843925491

Bennett, L. and Dyson, J. (2014) 'Deliberate Self-Harm', *Mental Health Practice*, 18(1), 14–20. https://doi.org/10.7748/mhp.18.1.**14**.e931.

Benton, T. and Craib, I. (2011) *Philosophy of Social Science: the Philosophical Foundations of Social Thought, 2nd edition.* London: Red Globe Press.

Biddle, L. (2003) 'Public hazards or private tragedies? An exploratory study of the effect of coroners' procedures on those bereaved by suicide', *Social Science & Medicine*, 56, pp. 1033–1045.

Booth, M. and Harriott, P. (2021) 'Service users being used: thoughts to the research Community' in Masson, I., Baldwin, L. and Booth, N. (eds), *Critical Reflections on Women, Family, Crime and Justice*, Policy Press, pp. 199–218. https://doi.org/10.1332/policypress/9781447358688.001.0001

Borrill, J., Paton, J., Regan, L., and Cassidy, T. (2004) 'The impact on staff of a self-inflicted death in custody', *Prison Service Journal*, (151), 2-6.

Borrill, J., Snow, L. Medlicott, D., Teers, R., Paton, J. (2005) 'Learning from "Near Misses": Interviews with Women who Survived an Incident of Severe Self-Harm in Prison', *The Howard Journal of Criminal Justice*, 44(1), 57–69.

Borrill, J. and Hall, J. (2006) 'Responding to a self-inflicted death in custody: support service and postvention', in G.E. Dear (ed.) *Preventing suicide and other self-harm in prison*. Palgrave Macmillan, pp. 195–205.

Bosk, C.L. (2014) 'Medical sociology as a vocation', *Journal of Health and Social Behavior*, 55(4), pp. 375–385. https://doi.org/10.1177/0022146514557131/FORMAT/EPUB.

Bouchard, K.L. (2016) 'Anonymity as a double-edge sword: Reflecting on the implications of online qualitative research in studying sensitive topics', *The Qualitative Report*, *21*(1), pp.59-67.

Boudoukha, A. *et al.* (2013) 'Inmates-to-Staff Assaults, PTSD and Burnout: Profiles of Risk and Vulnerability', *Journal of Interpersonal Violence*, 28(11), pp. 2332–2350. doi: 10.1177/0886260512475314.

Brabbs, C. (2016), "Independent overview report of Mrs BB", Norfolk Safeguarding Adults Board, Norwich.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.

Braun, V., Clarke, V., Hayfield, N. and Terry, G. (2019) 'Thematic analysis', in *Handbook of Research Methods in Health Social Sciences*. Springer Singapore, pp. 843–860. https://doi.org/10.1007/978-981-10-5251-4_103.

Braun, V. and Clarke, V. (2021) 'Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches', *Counselling and Psychotherapy Research*, 21(1), pp. 37–47. https://doi.org/10.1002/capr.12360.

Broadhurst, K., Wastell, D., White, S., Hall, C., Peckover and Davey, D. (2010) 'Performing 'Initial Assessment': Identifying the Latent Conditions for Error at the Front-Door of Local Authority Children's Services, *The British Journal of Social Work*, 40 (2), pp. 352–370, https://doi.org/10.1093/bjsw/bcn162

Brown, M. and Schept, J. (2017) 'New abolition, criminology and a critical carceral studies', *Punishment & Society,* 19(4), 440-462. https://doi.org/10.1177/1462474516666281

Bryman, A. (2012) *Social Research Methods,* 4th edition. Oxford: OUP.

Buck, G., Tomczak, P., Harriott, P., Page, R., Bradley, K., Nash, M. and Wainwright, L. (2023). 'Prisoners on prisons: Experiences of peer-delivered suicide prevention work', *Incarceration,* 4. https://doi.org/10.1177/26326663231172023

Burton, V. and Revell, L. (2018) 'Professional Curiosity in Child Protection: Thinking the Unthinkable in a Neo-Liberal World', *British Journal of Social Work*, 48, pp. 1508–1523. https://doi.org/10.1093/bjsw/bcx123.

Button, M.E. (2016) 'Suicide and Social Justice', *Source: Political Research Quarterly, (2016), 270-280, 69(2)*, 69(2), pp. 270–280. https://doi.org/10.1177/1065912916636689.

Button, M.E. (2019) 'Suicidal Regimes Public Policy and the Formation of Vulnerability to Suicide' in Button, M. E. and Marsh, I. (eds.) *Suicide and Social Justice.* Oxon: Routledge.

Calthorpe, B. and Choong, S. (2004), ''The coroner's court and the psychiatrist'', *Advances in Psychiatric Treatment*, 10, pp. 146-52.

Campbell, D and Hale, R. (2017) *Working in the Dark*. Oxford, Routledge.

Caputo-Levine, D.D. (2013) 'The yard face: The contributions of inmate interpersonal violence to the carceral habitus', *Ethnography*, 14(2), pp. 165–185. https://doi.org/10.1177/1466138112457299.

Carr, N. and Maguire, N. (2022) 'Criminal Court Time and Social Work Time: Pre-sentence Reports and the Chronotope of Adjourned Supervision', in *Time and Punishment.* Cham: Springer International.

Carter, S.M. *et al.* (2021) 'Conducting Qualitative Research Online: Challenges and Solutions', *Patient-Centered Outcomes Research,* 14(6), pp. 711–718. https://doi.org/10.1007/S40271-021-00528-W.

Casey, L. (2023) *The Casey Review: Final Report.* Available: https://www.met.police.uk/police-forces/metropolitan-police/areas/about-us/about-the-met/bcr/baroness-casey-review/

Cassidy, T. and Bruce, S. (2019) 'Dealing With Death in Custody: Psychosocial Consequences for Correctional Staff'. *Journal of Correctional Health Care*, 25(4), 304-312. doi: 10.1177/1078345819879752.

Cerel, J., Jones, B., Brown, M., Weisenhorn, D.A. and Patel, K. (2019) 'Suicide Exposure in Law Enforcement Officers', *Suicide and Life-Threatening Behavior*, 49(5), pp. 1281–1289. https://doi.org/10.1111/sltb.12516.

Chandler, A. (2016) *Self-injury, medicine and society: Authentic bodies*. London: Springer.

Chandler, A., and Simopoulou, Z. (2021) 'The Violence of the Cut: Gendering Self-Harm" *International Journal of Environmental Research and Public Health* 18 (9): 4650. https://doi.org/10.3390/ijerph18094650.

Chemtob, C.M., Bauer, G. B., Hamada, R. S. and Muraoka, M. Y. (1989) 'Patient Suicide: Occupational Hazard for Psychologists and Psychiatrists', *Professional Psychology: Research and Practice*, 20(5), pp. 294–300. https://doi.org/10.1037/0735-7028.20.5.294.

Clemmer, D. (1940) *The Prison Community*. New York: Holt, Rinehart and Winston.

Coffey, M. (1999) 'Stress and burnout in forensic community mental health nurses: an investigation of its causes and effects', *Journal of Psychiatric and Mental Health Nursing*, 6(6), pp. 433–443. https://doi.org/10.1046/J.1365-2850.1999.00243.X.

Cohen, S. and Taylor, L. (1972) *Psychological Survival: The Experience of Long-term Imprisonment.* Harmondsworth: Penguin.

Coles, D. and Ward, T. (1994) 'Failure stories: prison suicides and how not to prevent them' in Liebling, A. and Ward, T. (eds) *Deaths in Custody: International Perspectives*. London: Whiting and Birch. pp 127-142.

Corbin, J. M. and Strauss, A. L. (2015) *Basics of qualitative research: techniques and procedures for developing grounded theory* (4th edition). Thousand Oaks: Sage.

Coroners' Courts Support Service (2024), *FAQs,* https://coronerscourtssupportservice.org.uk/faq/

Council of Europe (2017) *Report to the Government of the United Kingdom on the Visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 30 March to 12 April 2016.* CPT/Inf (2017) 9.

Council of Europe (2020) *Report to the UK Government on the visit to the UK carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or punishment (CPT) from 13 to 23 May 2019*. https://rm.coe.int/ 16809e4404

Crawley, E. (2004a) *Doing Prison Work: The Public and Private Lives of Prison Officers.* Abingdon: Routledge.

Crawley, E. M. (2004b) 'Emotion and performance Prison officers and the presentation of self in prisons', *Punishment and Society*, 6((4)), pp. 411–427. doi: 10.1177/1462474504046121.

Crawley, E. and Crawley, P. (2008) 'Understanding prison officers: Culture, cohesion and conflict', in J. Bennett, B. Crewe, & A. Wahidin (eds.), *Understanding prison staff.* Cullompton: Willan.

Crewe, B. (2009) *The Prisoner Society: Power, Adaptation and Social Life in an English Prison.* Oxford: OUP.

Crewe, B. and Bennett, J. (eds.) (2011) *The Prisoner,* Oxon: Routledge.

Crewe, B., Liebling, A., & Hulley, S. (2011). Staff culture, use of authority and prisoner quality of life in public and private sector prisons. *Australian & New Zealand Journal of Criminology*, *44*(1), 94-115.

Crewe, B. Liebling, A. and Hulley, S. (2014) 'Heavy-light, absent-present: rethinking the "weight" of imprisonment'. *British Journal of Sociology,* 65, pp.387-410.

Cross, C. and McArdle, I. (2016) 'Reports to prevent further deaths', in Cross, C. and Garnham, N. (eds.) *The Inquest Book: The Law of Coroners and Inquests.* Oxford: Hart, pp 503–516

Crotty, M. (1998) *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks: Sage Publications.

Dale, C. and Woods, P. (2001), *Caring for Prisoners.* London: RCN.

Davidson, A.C., Berah, E. and Moss, S. (2006) 'The relationship between the adjustment of Australian police officers and their partners', *Psychiatry, Psychology and law*, 13, 41-48.

Davies, E., Maybury, B., Colquhoun, M., Whitfield, R., Rossetti, T. and Vetter, N. (2008) 'Public access defibrillation: psychological consequences in responders' *Resuscitation*, *77*(2), pp.201-206.

Davies, K. (1994) 'Time tensions in care work', *Time and Society*, 3 (3), 277–303.

Davies, M., Rolewicz, L., Schlepper, L., Fagunwa, F. (2020) *Locked out? Prisoners' use of hospital care*. Available https://www.nuffieldtrust.org.uk/files/2021-03/1614850952_prisoners-use-of-hospital-services-main-report.pdf

Dawson, P. and Buchanan, D. (2005) 'The way it really happened: Competing narratives in the political process of technological change', *Human Relations*, 58(7), 845–865.

Deakin, M., (2022) 'NHS workforce shortages and staff burnout are taking a toll'. *BMJ*, *377*.

Dear, G.E., Thomson, D.M. and Hills, A.M. (2000) 'Self-harm in prison: Manipulators can also be suicide attempters', *Criminal Justice and Behavior*, 27(2), pp. 160–175. https://doi.org/10.1177/0093854800027002002.

Debes, R. (ed.) (2017) *Dignity: a history.* Oxford: OUP.

de Freitas, C. R. and Grigorieva, E. A. (2015) Role of Acclimatization in Weather-Related Human Mortality During the Transition Seasons of Autumn and Spring. *International journal of environmental research and public health*, *12*(12), 14974–14987. https://doi.org/10.3390/ijerph121214962

DeHart, D. D., Smith, H. P. and Kaminski, R. J. (2009) 'Institutional responses to self-injurious behavior among inmates', *Journal of Correctional Health Care*, 15(2), 129–141. doi: 10.1177/1078345809331444.

Deiter P.J., Nicholls S.S. and Pearlman, L.A. (2000) 'Self-injury and self capacities: assisting an individual in crisis'. *Journal of Clinical Psychology*. 56(9):1173-1191. doi:10.1002/1097-4679(200009)56:9<1173::AID-JCLP5>3.0.CO;2-P

Delanty, G. and Strydom, P. (eds.) (2003) *Philosophies of social sciences*. Philadelphia: Open University.

Demoulin, S., Maurage, P. and Stinglhamber, F. (2021) 'Exploring metadehumanization and self-dehumanization from a target perspective', *The Routledge Handbook of Dehumanization*, pp. 260–274. doi: 10.4324/9780429492464-chapter17.

Dennard, S., Tracy, D.K., Beeney, A., Craster, L., Barton, M., Turrell, J., Poynton, S., Navkarov, V. and Kothari, R., (2021) 'Working in a prison: Challenges, rewards, and the impact on mental health and well-being'. *Journal of Forensic Practice,* 23(2), pp. 132-149.

Dewey, J. and Bentley, A. F. (1985) 'The Knowing and the Known', *Later Works 16,* Carbondale: Southern Illinois University Press.

Dey I. (1999) *Grounding Grounded Theory*. San Francisco, CA: Academic Press.

Dickinson, T., and Hurley, M. (2012) 'Exploring the antipathy of nursing staff who work within secure healthcare facilities to young people who self-harm'. *Journal of Advanced Nursing* 68(1), 147–158. doi: 10.1111/j.1365-2648.2011.05745.x.

Dickson-Swift, V., James, E. L., and Liamputtong, P. (2008), *Undertaking Sensitive Research in the Health and Social Sciences*. Cambridge: CUP.

DiMaggio, P. J. and Powell, W.W. 'Chapter 4: the Iron Cage Revisited: institutional isomorphism and collective rationality in organisational fields', in Dobbin, F. (ed) *The New Economic Sociology: A Reader*. Princeton: Princeton University Press, 2004, pp. 111-134. https://doi.org/10.1515/9780691229270-005

Dixon-Gordon, K., Harrison, N. and Roesch, R. (2012) 'Non-suicidal self-injury within offender populations: A systematic review', *International Journal of Forensic Mental Health*, 11(1), pp. 33–50. https://doi.org/10.1080/14999013.2012.667513.

Doka K. (1989) *Disenfranchised Grief: Recognizing the Hidden Sorrow*. Lexington Books, New York.

Dowden, C. and Tellier, C. (2004) 'Predicting work-related stress in correctional officers: A meta-analysis', *Journal of Criminal Justice*, 32(1), pp. 31–47. https://doi.org/10.1016/j.jcrimjus.2003.10.003.

Doyle, D. and McGrath, J. (2016) 'Attributing criminal responsibility for workplace fatalities and deaths in custody: corporate manslaughter in Britain and Ireland', in Fitz-Gibbon, K. and Walklate, S. (eds) *Homicide, Gender and Responsibility: An International Perspective*. Oxford: Routledge, pp 148–170.

Duffy, D. (2003) 'Exploring suicide risk and the therapeutic relationship: A case study approach', *NT Research* , 8(3), pp. 185–199. doi:10.1177/136140960300800304

Dumont, D.M. *et al.* (2012) 'Public health and the epidemic of incarceration', *Annual Review of Public Health*, 33, pp. 325–339. https://doi.org/10.1146/annurev-publhealth-031811-124614.

Durkheim, E. (1952) *Suicide*. London: Routledge.

Edge, C. *et al.* (2022) 'Integration, population commissioning and prison health and well-being – an exploration of benefits and challenges through the study of telemedicine', *Journal of Integrated Care*, 30(5), pp. 108–124. https://doi.org/10.1108/JICA-11-2021-0055.

Ellis, R. (2021) 'Prisons as porous institutions', *Theory and Society*. 50: 175–199. doi: 10.1007/s11186-020-09426-w.

Ellison, J. M. and Caudill, J. W. (2020) 'Working on local time: Testing the job-demand-control-support model of stress with jail officers', *Journal of Criminal Justice*, 70. p.101717. doi: 10.1016/j.jcrimjus.2020.101717.

Fair, H. and Walmsley, R. (2024) *World Prison Population List (14th edition)* London: ICPR. https://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_14th_edition.pdf

Favril, L., Yu, R., Hawton, K. and Fazel, S. (2020) 'Risk factors for self-harm in prison: a systematic review and meta-analysis', *The Lancet Psychiatry*, 7(8), pp. 682–691. https://doi.org/10.1016/S2215-0366(20)30190-5.

Fazel, S. and Baillargeon, J. (2011) 'The health of prisoners', *The Lancet*, pp. 956–965. https://doi.org/10.1016/S0140-6736(10)61053-7.

Fazel S., Grann M., Kling B., Hawton, K. (2011) 'Prison suicide in 12 countries: an ecological study of 861 suicides during 2003–2007'. *Social Psychiatry Psychiatric Epidemiology* 46: 191–95. https://doi.org/10.1007/s00127-010-0184-4

Farnsworth, J.K., Drescher, K.D., Evans, W. and Walser, R.D. (2017) 'A functional approach to understanding and treating military-related moral injury', *Journal of Contextual Behavioral Science*, *6*(4), pp.391-397.

Ferguson, H. (2016) 'How children become invisible in child protection work', *British Journal of Social Work*, 47(4), pp. 1007–1023. https://doi.org/10.1093/bjsw/bcw065.

Fiddler, M. and Jolliffe, D. (2016) Targeting 'terminal malignant alienation': Improving health literacy and reducing deaths in prison. Conference presentation.

Finney, C., Stergiopoulos, E., Hensel, J., Bonato, S., & Dewa, C. S. (2013) 'Organizational stressors associated with job stress and burnout in correctional officers', *BMC public health*, *13*, 82. https://doi.org/10.1186/1471-2458-13-82

Fitzpatrick, C., Hunter, K., Shaw, J., & Staines, J. (2023). Painful lives: Understanding self-harm amongst care-experienced women in prison. *Criminology & Criminal Justice*, 23(3), 348-365. https://doi.org/10.1177/17488958211067914

Fitzpatrick, S.J. (2016) 'Ethical and political implications of the turn to stories in suicide prevention', *Philosophy, Psychiatry and Psychology*, 23(3–4), pp. 265–276. https://doi.org/10.1353/ppp.2016.0029

Fitzpatrick, S.J. (2018) 'Reshaping the Ethics of Suicide Prevention: Responsibility, Inequality and Action on the Social Determinants of Suicide', *Public Health Ethics*, 11(2), pp. 179–190. https://doi.org/10.1093/PHE/PHX022.

Foo Fighters (2002) *All My Life.* New York: RCA.

Foote, C.E. and Frank, A.W. (1999) 'Foucault and Therapy: The Disciplining of Grief' in *Reading Foucault for Social Work.* New York: Columbia University. pp.157-187.

Foucault, M. (1977) *Discipline and Punish: the birth of the prison.* Middlesex: Penguin

Foucault, M. (1980) *Power-Knowledge: Selected Interviews and Other writings 1972-1976*, *Encyclopedia of Critical Psychology*. doi: 10.1007/978-1-4614-5583-7_438.

Foucault, M. (2002) 'Pompidou's two deaths' in Fabion, J. (ed), *Michel Foucault: Essential works of Foucault 1954-1984.* 418-422. London: Penguin.

Foucault, M. (2003) *Abnormal: Lectures at the College De France 1974-1975.* Trans. Burchell, G. and (ed.) Davidson, A. I., New York: Picador.

Foucault, Michel (2007). Security, Territory, Population: Lectures at the College de France 1977-78. New York: Picador and Palgrave Macmillan.

Frederiksen, M. (2014). Relational trust: Outline of a Bourdieusian theory of interpersonal trust. *Journal of Trust Research*, *4*(2), 167–192. https://doi.org/10.1080/21515581.2014.966829

Freshwater, D. (2005) 'Reflexivity and intersubjectivity in clinical supervision: on the value of not-knowing', in Johns, C. and Freshwater, D. (eds.) *Transforming Nursing Through Reflective Practice.* Oxford: Blackwell.

Fricker, M. (2007) *Epistemic Injustice: Power and the Ethics of Knowing*, Oxford Academic. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001

Fricker, M. (2018) 'Evolving Concepts of Epistemic Injustice' in Kidd, I.J. and Medina, J. (eds.) *The Routledge Handbook of Epistemic Injustice.* New York: Routledge.

Gaggliolo Gasteryger, G. and Elger, B. S. (2017) 'Death in Custody: Towards an International Framework for Investigation and Prevention' in Elger, B. S., Ritter, C. and Stöver, H. (eds.) *Emerging Issues in Prison Health.* Dordrecht : Springer. p. 35–53. doi: 10.1007/978-94-017-7558-8_3

Gair, S. (2012) 'Feeling their stories: Contemplating empathy, insider/outsider positionings, and enriching qualitative research'. *Qualitative health research,* 22(1), pp.134-143.

Gamble, A. (2015) 'Austerity as Statecraft'. *Parliamentary Affairs*, 68 (1), pp. 42–57. https://doi.org/10.1093/pa/gsu016

Garbutt, K. and Casey, H. (2015) 'Attitudes towards prisoners who self harm scale: A psychometric evaluation', *Journal of Aggression, Conflict and Peace Research*, 7(3), pp. 158–166. https://doi.org/10.1108/JACPR-08-2014-0133.

Garland, D. (1991) *Punishment and Modern Society: a Study in Social Theory.* Oxford: Clarendon Press.

Garland, D. (1996) 'The Limits of the Sovereign State: Strategies of Crime Control in Contemporary Society', *The British Journal of Criminology*, 36: 4, pp. 445-471 https://doi.org/10.1093/oxfordjournals.bjc.a014105https://academic.oup.com/bjc/article/36/4/445/459219.

Garland, D. (1997) 'The Punitive Society: Penology, Criminology and the History of the Present' *Edinburgh Law Review,* 1(2), pp. 180-199. *HeinOnline*, https://heinonline-org.nottingham.idm.oclc.org/HOL/P?h=hein.journals/edinlr1&i=198.

Garland, D. (2001) *The culture of control: Crime and social order in contemporary society.* Oxford: OUP.

Garland, D. (2018). Theoretical advances and problems in the sociology of punishment. Punishment & Society, 20(1), 8-33. https://doi.org/10.1177/1462474517737274

Garland, B.E. and McCarty, W.P. (2009) 'Job Satisfaction Behind Walls and Fences: A Study of Prison Health Care Staff', *Criminal Justice Policy Review*, 20, pp. 188–208. https://doi.org/10.1177/0887403409333261.

Garrihy, J. (2021) '"That Doesn't Leave You": Psychological Dirt and Taint in Prison Officers' Occupational Cultures and Identities', *The British Journal of Criminology*, 1–18. doi: 10.1093/bjc/azab074

Gaschino, E., Jones, V., Hall, L., Harrison, K., Mason, R. and Nichols, H. (2022). 'Just get on with it: A qualitative exploration of the health and wellbeing of prison operational managers and Governor grades: Project report for the Prison Governors Association'. Report. https://hdl.handle.net/10779/lincoln.24398401.v1

Geertz, C. (1973) 'Thick Description: Toward an Interpretive Theory of Culture', in C. Geertz, *The Interpretation of Cultures*. New York: Basic Books.

Gibbons, R., Brand, F., Carbonnier, A., Croft, A., Lascelles, K., Wolfart, G. and Hawton, K., (2019) 'Effects of patient suicide on psychiatrists: survey of experiences and support required'. *BJPsych Bulletin*, *43*(5), pp.236-241.

Glaser, B., and Strauss, A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Mill Valley, CA: Sociology Press.

Goddard, D., De Vries, K., McIntosh, T. and Theodosius, C. (2019) 'Prison nurses' professional identity'. *Journal of Forensic Nursing*, *15*(3), pp.163-171

Goffman, E. (1961) *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.

Goffman, E. (1986). Stigma: Notes on the management of spoiled identity. New York: Simon and Schuster.

Gov.uk (2024a) *Jury Service* https://www.gov.uk/jury-service

Gov.uk (2024b) *Urgent Notifications* https://www.gov.uk/government/collections/urgent-notification-process

Griffin, B.J. *et al.* (2019) 'Moral Injury: An Integrative Review', *Journal of Traumatic Stress*, 32(3), pp. 350–362. https://doi.org/10.1002/JTS.22362

Griffiths, R., Dawber, A., McDougall, T., Midgley, S. and Baker, J. (2022), 'Non-restrictive interventions to reduce self-harm amongst children in mental health inpatient settings'. *International Journal Mental Health Nursing*, 31: 35-50. https://doi.org/10.1111/inm.12940

Groves, A. (2004) 'Blood on the walls: Self-mutilation in prisons', *Australian and New Zealand Journal of Criminology*, 37(1), pp. 49–64. https://doi.org/10.1375/ACRI.37.1.49.

Guba, E.G. (1981) 'Criteria for assessing the trustworthiness of naturalistic inquiries', *Ectj*, *29*(2), pp.75-91.

Guerin, F. and Hallas, R. (2007) 'Introduction', in *The Image and the Witness: Trauma, Memory, and Visual Culture*. London: Wallflower, pp. 1–20.

Hansard (2024) *Prison Capacity* https://hansard.parliament.uk/Commons/2024-07-18/debates/FA393282-D6B3-4485-84C5-DAD88D0E9FB4/PrisonCapacity

Harvey, G. and Tapp, D.M. (2020) 'Exploring the meaning of critical incident stress experienced by intensive care unit nurses', *Nursing Inquiry*, 27(4), pp. 1–11. https://doi.org/10.1111/nin.12365.

Haslam, (2006) 'Dehumanization: An integrative review'. *Personality and Social Psychology Review*, 10, 252 – 264.

Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A. and Fazel, S., (2014) 'Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide'. *The Lancet*, *383*(9923), pp.1147-1154.

Hawton, K., and James, A. (2005) 'Suicide and deliberate self-harm in young people'. *British Medical Journal*, 330, 891Y894

Hegel, Georg. W. F. (2010) *Encyclopedia of the Philosophical Sciences in Basic Outline. Part 1: Science of Logic.* Cambridge: CUP.

Hellawell, D., (2006) 'Inside–out: analysis of the insider–outsider concept as a heuristic device to develop reflexivity in students doing qualitative research'. *Teaching in higher education*, *11*(4), pp.483-494.

Hennink, M.M., Kaiser, B.N. and Marconi, V.C. (2017) 'Code Saturation Versus Meaning Saturation: How Many Interviews Are Enough?', *Qualitative Health Research*. SAGE Publications Inc., pp. 591–608. https://doi.org/10.1177/1049732316665344.

Herman, J. (1992) *Trauma and Recovery: the aftermath of violence – from domestic abuse to political terror.* New York: Basic Books.

Hewson, T., Gutridge, K., Bernard, Z., Kay, K., & Robinson, L. (2022) 'A systematic review and mixed-methods synthesis of the experiences, perceptions and attitudes of prison staff regarding adult prisoners who self-harm', *BJPsych Open*, 8(4), pp. 1–12. https://doi.org/10.1192/bjo.2022.70.

HM Government and NHS England (2019) ***National Prison Healthcare Board Principle of Equivalence of Care for Prison Healthcare in England***

HM Inspectorate of Prisons (2018) *Urgent Notification Letter re: HMP Nottingham*, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/01/17jan-sofs-nottingham-letter-and-debrief-pack-for-publication-1.pdf

HM Inspectorate of Prisons (2023) *HM Chief Inspector of Prison for England and Wales annual report 2022-2023, https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/annual-report-2022-23/*

HMPPS (2021), *PSI 64/2011 Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*

HMPPS (2024a) *Facts About HM Prison Service,* https://prisonandprobationjobs.gov.uk/about-hmpps/about-the-prison-service/

HMPPS (2024b) *HMPPS workforce quarterly: June 2024,* https://www.gov.uk/government/statistics/hm-prison-and-probation-service-workforce-quarterly-june-2024/hm-prison-and-probation-service-workforce-quarterly-june-2024

HMPPS and Ministry of Justice (2023) *Offender management statistics quarterly: July to September 2022* https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2022/offender-management-statistics-quarterly-july-to-september-2022

HMPPS and Ministry of Justice (2024) *Offender management statistics quarterly: October to December 2023 and annual 2023* https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2023/offender-management-statistics-quarterly-october-to-december-2023-and-annual-2023

Hochschild, A. R. (1983) *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California Press.

Hoffman, M. L. (2000) 'Empathy's Limitations: Over-Arousal and Bias', in *Empathy and Moral Development: Implications for Caring and Justice.* Cambridge: CUP.

hooks, b., (1999) *All about Love: New Visions*. New York: William Morrow.

Hough, M., Allen, R. and Solomon, E. (eds.) (2008) *Tackling prison overcrowding: build more prisons? Sentence fewer offenders?*. Bristol: Policy Press.

House of Commons (2018) *Health Select Committee: Written evidence from the Royal College of Nursing* http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Health%20and%20Social%20Care/Prison%20health/written/83890.html#edn1

House of Commons (2022) *Justice Select Committee: Court Capacity.* London: House of Commons https://committees.parliament.uk/publications/21999/documents/163783/default/

Independent Advisory Panel on Deaths in Custody and Royal College of Nursing (2020) https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/21/2023/12/200929IAP-RCN-preventionofnaturaldeathsincustody-finalforpublication.pdf

Independent Monitoring Boards (2023) *Annual Report of the Independent Monitoring Board at HMP/YOI Foston Hall, 1 December 2021 – 30 November 2022.* https://imb.org.uk/document/foston-hall-2021-22-annual-report/

Inquest (2022) https://www.inquest.org.uk/alex-braund-inquest [https://www.judiciary.uk/wp-content/uploads/2023/01/Alexander-Braund-Prevention-of-future-deaths-report-2022-0407_Published.pdf]

Institute for Government (2018) *Performance tracker: autumn 2018: prisons* https://www.instituteforgovernment.org.uk/publication/performance-tracker-2018/prisons

Institute for Government (2023) *Performance tracker 2023* https://www.instituteforgovernment.org.uk/sites/default/files/2024-01/performance-tracker-2023.pdf

Ireland, J.L. and Quinn, K. (2007) 'Officer Attitudes Towards Adult Male Prisoners Who Self-Harm', *AGGRESSIVE BEHAVIOR*, 33, pp. 63–72. https://doi.org/10.1002/ab.20168.

Isenhardt, A., and Hostettler, U. (2020) 'Inmate violence and correctional staff burnout: The role of sense of security, gender, and job characteristics', *Journal of Interpersonal Violence, 35*(1-2), 173–207. https://doi.org/10.1177/0886260516681156

Ismail, N. (2019a) 'Perspectives Rolling back the prison estate: the pervasive impact of macroeconomic austerity on prisoner health in England', *Journal of Public Health*, 42(3), pp. 625–632. https://doi.org/10.1093/pubmed/fdz058.

Ismail, N. (2019b) 'Contextualising the pervasive impact of macroeconomic austerity on prison health in England: a qualitative study among international policymakers'. *BMC Public Health* **19**, 1043 https://doi.org/10.1186/s12889-019-7396-7

Ismail, N. (2020a) 'Deterioration, drift, distraction, and denial: How the politics of austerity challenges the resilience of prison health governance and delivery in England', *Health Policy*, 124(12), pp. 1368–1378. https://doi.org/10.1016/j.healthpol.2020.09.004.

Ismail N. (2020b) 'The politics of austerity, imprisonment and ignorance: A case study of English prisons'. *Medicine, Science and the Law*. 2020;60(2):89-92. doi:10.1177/0025802419899744

Ismail, N. (2023) *The English Prison health system after a decade of austerity 2010–2020*. London: Taylor and Francis.

Jacobson N. (2007) 'Dignity and health: a review'. *Social Science and Medicine* 64: 292–302 https://doi.org/10.1016/j.socscimed.2006.08.039

James, L. and Todak, N. (2018) 'Prison employment and post-traumatic stress disorder: Risk and protective factors', *American Journal of Industrial Medicine*, 61(9), 725–732. doi: 10.1002/ajim.22869.

Jewkes, Y., Jordan, M., Wright, S., and Bendelow, G. (2019) 'Designing "Healthy" Prisons for Women: Incorporating Trauma-Informed Care and Practice (TICP) into Prison Planning and Design', *International Journal of Environmental Research and Public Health*, 16(20). https://doi.org/10.3390/ijerph16203818.

Johnson, T.P. (2014) 'Snowball Sampling: Introduction', in N. Balakrishnan, T. Colton, B. Everitt, W. Piegorsch, F. Ruggeri and J.L. Teugels (eds.) *Wiley Stats Ref: Statistics Reference Online*.

Jordan, M. (2011) 'The prison setting as a place of enforced residence, its mental health effects, and the mental healthcare implications', *Health and Place*, 17, pp. 1061–1066. https://doi.org/10.1016/j.healthplace.2011.06.006.

Jordan, M. (2012) 'Patients'/prisoners' perspectives regarding the National Health Service mental healthcare provided in one Her Majesty's Prison Service establishment', *Journal of Forensic Psychiatry & Psychology*, 23(5–6), pp. 722–739. https://doi.org/10.1080/14789949.2012.733722.

Kalinich and Pitcher (1984) *Surviving in Corrections.* Springfield: Charles C. Thomas.

Kalra, R., Glowa Kollisch, S., MacDonald, R., Dickey, N., Rosner, Z. and Venters, H. (2016) 'Staff Satisfaction, Ethical Concerns, and Burnout in the New York City Jail Health System', *Journal of Correctional Health Care*, 22(4), pp. 383–392. https://doi.org/10.1177/1078345816668339.

Karman, P., Kool, N., Poslawsky, I. E. and Van Meijel, B. (2015) 'Nurses' attitudes towards self-harm: A literature review', *Journal of Psychiatric and Mental Health Nursing*, 22(1), pp. 65–75. doi: 10.1111/JPM.12171.

Kasket, E. (2006) 'Death and the Doctor II: A Phenomenological Investigation', *Existential Analysis, 17*(2), 385–396.

Kemp, T. and Tomczak, P. (2023) 'The Cruel Optimism of International Prison Regulation: Prison Ontologies and Carceral Harms', *Law & Social Inquiry*, *49*(3), 1683–1714. doi:10.1017/lsi.2023.63

Kenning, C., Cooper, J., Short, V., Shaw, J., Abel, K., and Chew-Graham, C. (2010) 'Prison staff and women prisoner's views on self-harm; their implications for service delivery and development', *Criminal Behaviour and Mental Health*, 20(4), 274–284. doi:10.1002/cbm.777

Kerr, C., Nixon, A., and Wild, D. (2010) 'Assessing and demonstrating data saturation in qualitative inquiry supporting patient-reported outcomes research', *Expert review of pharmacoeconomics & outcomes research*, *10*(3), 269–281. https://doi.org/10.1586/erp.10.30

Kimbrel, N.A., Pennington, M.L., Cammarata, C.M. and Gulliver, S.B. (2016) 'Is Cumulative Exposure to Suicide Attempts and Deaths a Risk Factor for Suicidal Behavior Among Firefighters?', *Suicide and Life-Threatening Behavior*, 46(6), pp. 669–677. https://doi.org/10.1111/SLTB.12248.

King, D. B. and Delongis, A. (2014) 'When couples disconnect: Rumination and withdrawal as maladaptive responses to everyday stress'. *Journal of Family Psychology*, 28, 460.

Kinman, G., Clements, A.J. and Hart, J. (2016) 'Work-related wellbeing in UK prison officers: A benchmarking approach', *International Journal of Workplace Health Management*, 9(3), pp. 290–307. https://doi.org/10.1108/IJWHM-09-2015-0054.

Kinman, G., Clements, A. J. and Hart, J. (2017) 'Job demands, resources and mental health in UK prison officers', *Occupational Medicine*, 67(6), pp. 456–460. doi: 10.1093/OCCMED/KQX091.

Kinner, S. A., & Wang, E. A. (2014). The case for improving the health of ex-prisoners. *American journal of public health*, *104*(8), 1352–1355. https://doi.org/10.2105/AJPH.2014.301883

Kirk, D., S. and Wakefield, S., (2018) 'Collateral Consequences of Punishment: A Critical Review and Path Forward', *Annual Review of Criminology,* 1:1, 171-194

Kirk-Wade, E. (2025) *Suicide Statistics.* House of Commons Library: London.

Klaas P.B., Berge, K.H., Klaas, K.M., Klaas, J.P. and Larson A.N. (2014) 'When patients are harmed, but are not wronged: ethics, law, and history', *Mayo Clin Proc.* 89(9): 1279-1286.

Knapman, P. (2006), ''The role of the coroner: what you need to know for the foundation years'', *British Journal of Hospital Medicine*, 67(2), pp. M34-5.

Kothari, R., Forrester, A., Greenberg, N. Sarkissian, N., and Tracy, D. K. (2020) 'COVID-19 and prisons: Providing mental health care for people in prison, minimising moral injury and psychological distress in mental health staff'. *Medicine, Science and the Law*, 60(3), pp. 165-168, doi: 10.1177/0025802420929799

Kottler, C., Smith, J. G. and Bartlett, A. (2018) 'Patterns of violence and self-harm in women prisoners: characteristics, co-incidence and clinical significance', *Journal of Forensic Psychiatry and Psychology*. Routledge, 29(4), pp. 617–634. doi: 10.1080/14789949.2018.1425475.

Kruttschnitt, C. and Gartner, R. (2005) *Marking Time in the Golden State: Women's Imprisonment in California*. Cambridge: CUP.

Krzyżanowski, M. (2020) 'Normalization and the discursive construction of "new" norms and "new" normality: discourse in the paradoxes of populism and neoliberalism', *Social Semiotics*, *30*(4), 431–448. https://doi.org/10.1080/10350330.2020.1766193

Lambert, E.G., Altheimer, I. and Hogan, N.L. (2010) 'Exploring the Relationship Between Social Support and Job Burnout Among Correctional Staff', *Criminal Justice and Behaviour,* 37(11), pp. 1217–1236. https://doi.org/10.1177/0093854810379552.

Lambert, E. G., Hogan, N. L., Barton-Bellessa, S. M., & Jiang, S. (2012) 'Examining the Relationship Between Supervisor and Management Trust and Job Burnout Among Correctional Staff', *Criminal Justice and Behavior*, *39*(7), 938-957

https://doi.org/10.1177/0093854812439192

Lambert, E.G, Minor, K. I., Wells, J. B., and Hogan, N. L. (2016) 'Social support's relationship to correctional staff job stress, job involvement, job satisfaction, and organizational commitment', *Social Science Journal*, 53(1), pp. 22–32. https://doi.org/10.1016/j.soscij.2015.10.001.

Lee, H., Mccormick, T., Hicken, M. T., Wildeman, C. (2015) 'Racial Inequalities in Connectedness to Imprisoned Individuals in the United States'. *Du Bois Review*, 12(2), 269–282. doi:10.1017/S1742058X15000065

Lemmergaard, J. and Muhr, S.J. (2012) 'Golfing with a murderer—Professional indifference and identity work in a Danish prison', *Scandinavian Journal of Management*. (28, 2), pp. 185-195, https://doi.org/10.1016/j.scaman.2011.10.001.

Liebling, A. (1992) *Suicides in Prison*. London: Routledge.

Liebling, A. (1998) 'Managing to Prevent Prison Suicide: Are Staff at Risk Too?' in J. B. Kamerman (ed.), *Negotiating Responsibility in the Criminal Justice System*. Carbondale, IL: Southern Illinois University Press, pp. 68– 86.

Liebling, A. (1999) 'Prison Suicide and Prisoner Coping', *Crime and Justice*, 26, 283–359. doi: 10.1086/449299.

Liebling, A. (2007) 'Why prison staff culture matters', in Byrne, J., Taxman, F. and Hummer, D. (eds) *The Culture of Prison Violence*. Boston, MA: Allyn and Bacon, 105–122.

Liebling, A. (2011) 'Moral performance, inhuman and degrading treatment and prison pain', *Punishment and Society*, 13(5), 530–550. doi: 10.1177/1462474511422159.

Liebling A. (2017) 'The Meaning of Ending Life in Prison', *Journal of Correctional Health Care*. 23(1): 20-31. doi:10.1177/1078345816685070

Liebling, A. (2019) 'Prisons, personal development, and austerity' in *The Routledge companion to rehabilitative work in criminal justice*, pp. 193-206. Routledge.

Liebling, A. (2020) 'Finding George Eliot in prison: reflections on its moral life'. *George Eliot Review*, (51).

Liebling, A. (2023) Written evidence submission to Education Select Committee.

Liebling, A., Hulley, S. and Crewe, B. (2012) 'Conceptualising and Measuring the Quality of Prison Life' in Gadd, D., Karstedt, S. and Messner, S. F. (eds), *The SAGE Handbook of Criminological Research Methods*. London: SAGE Publications Ltd. pp. 358-372.

Liebling, A. and Krarup, H. (1993) *Suicide attempts and self-injury in male prisons*. HM Stationery Office.

Liebling, A., Laws, B., Lieber, E., Auty, K., Schmidt, B.E., Crewe, B., Gardom, J., Kant, D. and Morey, M. (2019) 'Are hope and possibility achievable in prison?'. *The Howard Journal of Crime and Justice*, *58*(1), pp.104-126.

Liebling, A. and Ludlow, A. (2016) 'Suicide, distress and the quality of prison life', in: Y. Jewkes, B. Crewe, and J. Bennett (eds.) *Handbook on prisons*. 224–245. Abingdon: Routledge.

Liebling, A., Price, D. and Sheffer, G. (2012) *The Prison Officer*. 2nd edition. Abingdon: Routledge.

Liebling, A., Tait, S., Durie, L., Stiles, A. and Harvey, J. (2005), *An evaluation of the safer locals programme*. Cambridge ICPRC. Cambridge, Generic.

Lilleker, D. G. (2003) 'Interviewing the Political Elite: Navigating a Potential Minefield', *Politics*, 23(3), 207–214.

Liu, L.X., Goldszmidt, M., Calvert, S., Burm, S., Torti, S., Cristancho, S. and Sukhera, J. (2022) 'From distress to detachment: exploring how providing care for stigmatized patients influences the moral development of medical trainees', *Adv in Health Sci Educ* **27**, 1003–1019 https://doi.org/10.1007/s10459-022-10125-7

Lincoln, Y.S. and Guba, E.G., 1985. *Naturalistic inquiry*. Newberry Park.

Litz, B.T., Stein, N., Delaney, E., Lebowitz, L. and Maguen, S. (2009) 'Moral injury and moral repair in war veterans', *Clinical Psychology Review,* 29, 695–706. https://doi.org/10.1016/j.cpr.2009.07.003

Litz, B.T. and Kerig, P.K. (2019) 'Introduction to the Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications', *Journal of Traumatic Stress*, 32(3), pp. 341–349. https://doi.org/10.1002/jts.22405.

Ludlow, A., Schmidt, B., Akoensi, T., Liebling, A., Giacomantonio, C. and Sutherland, A. (2015) 'Self-inflicted Deaths in NOMS' Custody Amongst 18-24 Year Olds: Staff Experience, Knowledge and Views', *Self-inflicted Deaths in NOMS' Custody Amongst 18-24 Year Olds: Staff Experience, Knowledge and Views (Harris Review).* doi: 10.7249/rr916.

MacDonald, M. (2018). 'Overcrowding and its impact on prison conditions and health', *International Journal of Prisoner Health*, 14(2), 65–68. doi: 10.1108/IJPH-04-2018-0014.

Malik, S., Gunn, S. and Robertson, N. (2021) 'The Impact Of Patient Suicide on Doctors and Nurses: A Critical Interpretive Meta-Synthesis', *Archives of Suicide Research* [Preprint]. https://doi.org/10.1080/13811118.2021.1885533.

Manning, N. (2019) 'Sociology, biology and mechanisms in urban mental health', *Social Theory and Health*, 17(1), pp. 1–22. https://doi.org/10.1057/s41285-018-00085-7.

Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020) *Health equity in England: The Marmot Review 10 years on*. London: Institute of Health Equity.

Marsh, I. (2010) *Suicide: Foucault, History and Truth*. Cambridge: CUP.

Martin, T.M. and Jefferson, A.M. (2019) 'Prison Ethnography in Africa: reflections on a maturing field', *Politique Africaine*, 155(3), pp. 131–152. https://doi.org/10.3917/polaf.155.0131.

Marx, K. (1844, 1961), M. Mulligan (Trans.). *Economic and philosophic manuscripts of 1844*. Moscow: Foreign Languages Publishing House.

Marzano, L. and Adler, J.R., (2007) 'Supporting staff working with prisoners who self-harm: A survey of support services for staff dealing with self-harm in prisons in England and Wales', *International Journal of Prisoner Health*.

Marzano, L. (2010) 'Self-harm in prisons: dominant models and (mis)understandings', in Adler, J. R. and Gray, J. M. (eds), pp. 486–507.

Marzano, L., Adler, J. R. and Ciclitira, K. (2013) 'Responding to repetitive, non-suicidal self-harm in an English male prison: Staff experiences, reactions, and concerns', *Legal and Criminological Psychology*, 20(2), 241–254. doi: 10.1111/lcrp.12025.

Marzano, L., Hawton, K., Rivlin, A., Smith, E. N., Piper, M. and Fazel, S. (2016) 'Prevention of Suicidal Behavior in Prisons: An Overview of Initiatives Based on a Systematic Review of Research on Near-Lethal Suicide Attempts', *Crisis*, 37(5), pp. 323-334. https://doi.org/10.1027/0227-5910/A000394.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001) 'Job burnout', *Annual Review of Psychology, 52,* 397–422. https://doi.org/10.1146/annurev.psych.52.1.397

Maycock, M. (2022) '"Covid-19 has caused a dramatic change to prison life". Analysing the impacts of the Covid-19 pandemic on the pains of imprisonment in the Scottish Prison Estate', *The British Journal of Criminology*. 62(1), 218–233. doi: 10.1093/BJC/AZAB031.

McCann, T., Clark, E., McConnachie, S. and Harvey, I. (2006) 'Accident and emergency nurses' attitudes towards patients who self-harm', *Accident and Emergency Nursing,* 14(1), pp. 4-10 https://doi.org/10.1016/j.aaen.2005.10.005.

McDonald, M. and Fallon, P. (2008) 'Health Professionals in Prison', in J. Bennett, B. Crewe and A. Wahidin (eds.), *Understanding Prison Staff*, Willan Publishing, 349-368.

McGuire, J. (2018) *Understanding prison violence: a rapid evidence assessment*.

McKendy, L., Ricciardelli, R. and Konyk, K. (2021) 'Trauma in the correctional field and the correctional worker habitus', *Incarceration*, 2((2)), pp. 1–18. https://doi.org/10.1177/26326663211021727.

McLeod, A. M. (2015) 'Prison Abolition and Grounded Justice', UCLA Law Review 5, 2015: 1156–1239

McLeod, K. E., Martin, R. E., Borschmann, R., Kinner, S. A., Sturup-Toft, S., Dolan, K., Acheampong, L. K., Topp, S. M. *et al.* (2020) 'Global prison health care governance and health equity: A critical lack of evidence', *American Journal of Public Health*, 110(3), 303–308.

Mealer, M. and Jones, J. (2013) 'Methodological and ethical issues related to qualitative telephone interviews on sensitive topics', *Nurse Researcher.*, 21(4), pp. 32–37.

Menzies Lyth, I. (1988) *Containing anxiety in institutions. Selected Essays, Volume 1.* London: Free Association Books.

Merton, R. (1972) 'Insiders and outsiders; a chapter in the sociology of knowledge'. *American Journal of Sociology*, 78(1), 9-47.

Mikecz, R. (2012) 'Interviewing Elites: Addressing Methodological Issues', *Qualitative Inquiry*, 18(6), 482–493.

Mills, C. (2018) '"Dead people don't claim": A psychopolitical autopsy of UK austerity suicides', *Critical Social Policy*, 38(2), pp. 302–322. https://doi.org/10.1177/0261018317726263.

Ministry of Justice (2020) *A Guide to Coroners Services for Bereaved People.* (Ministry of Justice: London)

Ministry of Justice (2021) *Prisons Strategy White Paper.* London: HMSO.

Ministry of Justice (2023) *Safety in Custody, quarterly update to December 2022.* London: Ministry of Justice.

Ministry of Justice (2024a) *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2024 Assaults and Self-harm to December 2023.* [https://assets.publishing.service.gov.uk/media/66290c6d3b0122a378a7e60c/safety-in-custody-q4-2023.pdf]

Ministry of Justice (2024b) *Self-harm in prison custody 2004 to 2023.* [https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2023]

Ministry of Justice (2024c) *Population Bulletin: weekly, 30 August 2024*, https://www.gov.uk/government/publications/prison-population-figures-2024

Ministry of Justice (2024d) *Costs per place and costs per prisoner by individual prison* https://assets.publishing.service.gov.uk/media/65f4229810cd8e001136c655/costs-per-place-per-prisoner-2022-2023-summary.pdf

Ministry of Justice (2025) *Death in Prison Custody 1978 – 2024,* London: Ministry of Justice.

Ministry of Justice and Office of National Statistics (2024) *Prison Population Projections 2023 to 2028, England and Wales* [https://assets.publishing.service.gov.uk/media/65df5123b8da630f42c86271/Prison_Population_Projections_2023_to_2028.pdf]

Möllering, G. (2013) 'Process views of trusting and crises', *Handbook of Advances in Trust Research*, pp. 285–305. https://doi.org/10.4337/9780857931382.00024.

Montgomery A., Panagopoulou, E., Esmail, A., Richards, T. and Maslach, C. (2019) 'Burnout in healthcare: the case for organisational change'. *BMJ*. 366: l4774. doi:10.1136/bmj.l4774

Morgan, H. G. (1979) *Death Wishes: The Understanding and Management of Deliberate Self Harm*. Chichester: Wiley.

Morgan, H. G. and Priest, P. (1984) 'Assessment of Suicide Risk in Psychiatric In-Patients'. *British Journal of Psychiatry* 145:467-9.

Morrison, K., & Maycock, M. (2020) 'Becoming a Prison Officer: An Analysis of the Early Development of Prison Officer Cultures ', *The Howard Journal of Crime and Justice*, 60(1), 3-24. https://doi.org/10.1111/hojo.12394

NAPICU (2017) *Design Guidance for Psychiatric Intensive Care Units 2017.* Glasgow: NAPICU International Press.

Nayak, A. and Chia, R. (2011) 'Philosophy and Organization Theory Research in the Sociology of Organizations', *Research in the Sociology of Organizations*, 32, 281–309. doi: 10.1108/S0733-558X(2011)0000032012.

Natow, R. S. (2020) 'The use of triangulation in qualitative studies employing elite interviews', *Qualitative Research*. Davies, 20(2), 160–173.

Nellis, M. (2002) 'Community Justice, Time and the New National Probation Service'. *The Howard Journal of Criminal Justice*, 41: 59-86. https://doi.org/10.1111/1468-2311.00225

Nelson, J., (2017) 'Using conceptual depth criteria: addressing the challenge of reaching saturation in qualitative research'. *Qualitative research*, *17*(5), pp.554-570.

Nelson, P.A. *et al.* (2020) '"We're the First Port of Call" – Perspectives of Ambulance Staff on Responding to Deaths by Suicide: A Qualitative Study', *Frontiers in Psychology*, 11. https://doi.org/10.3389/fpsyg.2020.00722.

NHSE (2022) *Health and justice framework for integration 2022-2025: Improving lives – reducing inequality.* https://www.england.nhs.uk/long-read/health-and-justice-framework-for-integration-2022-2025-improving-lives-reducing-inequality/

Nixon, S. (2022) '"You can't un-see what you've seen": An ex-prison officer's autoethnographic account of suicide and self-harm in a UK male adult prison', *Incarceration*, 3(2), p. 263266632211049. https://doi.org/10.1177/26326663221104994.

Nylander, P.Å., Lindberg, O. and Bruhn, A. (2011) 'Emotional labour and emotional strain among Swedish prison officers', *European Journal of Criminology*, 8(6), pp. 469–483. https://doi.org/10.1177/1477370811413806.

O'Connor, H. *et al.* (2008) 'Internet-based Interviewing' in Fielding, N., Lee, R. M. and Blank, G. *The SAGE handbook of online research methods*. SAGE Publications Ltd. https://doi.org/10.4135/9780857020055

O'Donnell, O., House, A. and Waterman, M. (2015) 'The co-occurrence of aggression and self-harm: Systematic literature review', *Journal of Affective Disorders*, 175, pp. 325-350. https://doi.org/10.1016/j.jad.2014.12.051

O'Hara, D., Da Silva Guerreiro, J. and Lefebvre, J. (2021) 'Attitudes of Forensic Psychiatric Staff to Self-Harm Behaviors of Their Female Patients', *International Journal of Forensic Mental Health*, 21:4, 361-371, DOI: 10.1080/14999013.2021.2009596

O'Moore, E.J. (2016) *Afternoon Keynote Address: Delivering Effective Healthcare in Prisons*.

Office of National Statistics (2024) *Suicides in England and Wales datasets* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables

Oliver, M. (2006) *Owls and Other Fantasies: poems and essays*. Boston: Beacon Press.

Palgi, Y., Ben-Ezra, M., Lange, S. and Essar, N. (2009) 'The effect of prolonged exposure to war stress on the comorbidity of PTSD and depression among hospital personnel', *Psychiatry Research*. 168 (3): 262–4.

Pannell, J., Howells, K., and Day, A. (2003*)* 'Prison officer's beliefs regarding self-harm in prisoners : an empirical investigation', *International Journal of Forensic Psychology, 1, 103–110.*

Pantazis, C. (2016) 'Policies and Discourses of Poverty During a Time of Recession and Austerity', *Critical Social Policy*. 36(1), pp. 3– 20.

Papadopoulou, L., Angelou, I., & Katsaounidou, A. (2024) "I love my job, but my job is destroying me". Permacrisis' toll on journalistic practice and perceptions about journalism in Southern Europe. *Journalism*, *0*(0). https://doi.org/10.1177/14648849241272219

Papazoglou, K. *et al.* (2020) 'The Role of Moral Injury in PTSD Among Law Enforcement Officers: A Brief Report', *Frontiers in Psychology*, 11. https://doi.org/10.3389/fpsyg.2020.00310.

Parker, C., Scott, S. and Geddes, A. (2020) 'Snowball Sampling', in *SAGE Research Methods Foundations*. SAGE Publications Ltd. https://doi.org/10.4135/9781526421036831710.

Parkes, R., Graham-Kevan, N. and Bryce, J. (2019) 'I put my "police head" on: Coping strategies for working with sexual offending material', *The Police Journal*, 92(3), 237–263. https://doi.org/10.1177/0032258X18808294

Patenaude, Al. L. (2004) 'No Promises, But I'm Willing to Listen and Tell What I Hear: Conducting Qualitative Research Amongst Prison Inmates and Staff', *The Prison Journal*, 84(4).

Patterson, P., Whittington, R. and Bogg, J. (2007) 'Measuring nurse attitudes towards deliberate self-harm: The Self-Harm Antipathy Scale (SHAS)', *Journal of Psychiatric and Mental Health Nursing*, 14(5), 438–445.

Patton, M. (1999) 'Enhancing the quality and credibility of qualitative analysis', *Health Services Research,* 34 (5 Pt 2), 1189–1208.

Peacock, M., Turner, M. and Varey, S. (2018) ' "We call it jail craft": The erosion of the protective discourses drawn on by prison officers dealing with ageing and dying prisoners in the neoliberal, carceral system', *Sociology*, *52*(6), 1152-1168.

Pearlman, L. A. and Saakvitne, K.W. (2013) 'Treating therapists with vicarious traumatization and secondary, traumatic stress disorders', in Figley, C. R. (ed.) *Compassion Fatigue: Coping with Traumatic Stress Disorder in those who Treat the Traumatized*. Routledge, London, pp. 150–155.

Penal Reform International (2018) *Health – key facts*. Available: https://www.penalreform.org/issues/prison-conditions/key-facts/

Perrett, S., Plugge, E., Conaglen, P., O'Moore, E. and Stürup-Toft, S. (2019) 'The Five Nations model for prison health surveillance: lessons from practice across the UK and Republic of Ireland', *Public Health Specialist Journal of Public Health,* 42:4, pp.e561-572 https://doi.org/10.1093/pubmed/fdz122

Peters, J.D. (2001) 'Witnessing'. *Media, Culture & Society* 23(6): 707–723. DOI: 10.1177/016344301023006002

Phillips, J., Ainslie, S., Fowler, A. and Westaby, C. (2022) ' "What does professional curiosity mean to you?": an exploration of professional curiosity in probation', *The British Journal of Social Work*, 52 (1) pp. 554–572.

Pike and George (2019) *The Assessment, Care in Custody and Teamwork (ACCT) process in prison: findings from qualitative research*. Ministry of Justice: London. https://assets.publishing.service.gov.uk/media/5c936b7a40f0b633fa716122/acct-process-prison-findings-from-qualitative-research.pdf

Piper, M., Forrester, A. and Shaw, J. (2019) 'Prison Healthcare Services: the need for political courage', *The British Journal of Psychiatry.* 215: 579–581. doi:10.1192/bjp.2019.43

Plugge, E., Stürup-Toft, S., Møller, L., O'Moore, E. (2017) 'Worldwide prison health research and engagement network: a vehicle for capacity-building in prison health', *Public Health Panorama*, 03(03), 483–488.

Podmore, J. (2012) *Out of Sight, Out of Mind: why Britain's prisons are failing.* London: Biteback Publishing.

Politics Home (2017) *Bob Neill: Our Prisons Crisis Cannot be Swept Under the Carpet.* [Available at: https://www.politicshome.com/thehouse/article/bob-neill-our-prison-crisis-cannot-be-swept-under-the-carpet]

Pompili, M., Girardi, P., Ruberto, A. and Tatarelli, R., (2005) 'Suicide in borderline personality disorder: a meta-analysis'. *Nordic journal of psychiatry*, *59*(5), pp.319-324.

Pope, L. (2018) *Self-harm by adult men in prison: A rapid evidence assessment (REA)*. London: Ministry of Justice. Available at https://www.gov.uk/government/publications/self-harm-by-adult-men-in-prison-a-rapid-evidence-assessment

Popescu, D. (2018) 'The Importance of Bearing Witness', *East European Politics and Societies*, *32*(2), 315-319. https://doi.org/10.1177/0888325417745129

Porges, S.W. (2022) 'Polyvagal Theory: A Science of Safety', *Frontiers in Integrative Neuroscience*, 16, p. 27. https://doi.org/10.3389/FNINT.2022.871227/BIBTEX

Power, J. and Usher, A. (2014). *Working with Offenders who Self-Injure: Staff Resilience in High Stress Situations*. Research Report R276. Ottawa: Correctional Service of Canada.

Prisons and Probation Ombudsman (PPO) (2022) *Prisons and Probation Ombudsman Annual Report, 2021-22*. London: HMSO.

PPO/CSEW (2012) *Memorandum of Understanding between the Prisons and Probation Ombudsman (PPO) and the Coroners Society of England and Wales (CSEW)*. Available: https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/14/2024/07/Memorandum_of_Understanding_with_Coroners_-_approved_July_2012.pdf

Prison Reform Trust, Prisoner Policy Network (2020) *CAPPTIVE: Regimes, reactions to the pandemic, and progression.* London: Prison Reform Trust.

Prison Reform Trust (2024) *Bromley Briefings Prison Factfile.* London: Prison Reform Trust. Available: https://prisonreformtrust.org.uk/wp-content/uploads/2024/02/Winter-2024-factfile.pdf

Pugh, J. and Grove, K. (2015) 'Assemblage Thinking and Participatory Development ', *Geography Compass*, 9(1), pp. 1–13.

Quinn, K., Tomczak, P. and Buck, G. (2022) '"How you keep going": Voluntary sector practitioners' story-lines as emotion work', *British Journal Sociology*, 73, pp. 370–386. https://doi.org/10.1111/1468-4446.12914

Ramluggun, P. (2013) 'A Critical Exploration of the Management of Self-Harm in a Male Custodial Setting: Qualitative Findings of a Comparative Analysis of Prison Staff Views on Self-Harm', *Journal of Forensic Nursing*, 9(1), 23-34. doi: 10.1097/JFN.0b013e31827a5984.

Ramsbotham, D. (2003) *Prisongate: the shocking state of Britain's prisons and the need for visionary change*. London: The Free Press.

Raymen, T. (2022) *The Enigma of Social Harm: The Problem of Liberalism*. London: Routledge. https://doi.org/10.4324/9781003098546

Rayner, G., Blackburn, J., Edward, K. L., Stephenson, J. and Ousey, K. (2019) 'Emergency department nurse's attitudes towards patients who self-harm: A meta-analysis', *International Journal of Mental Health Nursing*, 28(1), 40–53. doi: 10.1111/inm.12550.

Read, M. and Noonan, I. (2018) 'What does hope mean when working with suicidal prisoners?', *British Journal of Mental Health Nursing*, 7(1), 24–31. doi: 10.12968/bjmh.2018.7.1.24.

Rees, N., Rapport F., Snooks, H., John, A. and Patel, C. (2016) 'How do emergency ambulance paramedics view the care they provide to people who self harm?', *International Journal of Law and Psychiatry*. 2017;50:61-67. doi:10.1016/j.ijlp.2016.05.010.

Regehr, C., Carey, M., Wagner, S., Corneil, W., White, N. (2019) 'Prevalence of PTSD, Depression and Anxiety Disorders in Correctional Officers: A Systematic Review', *Corrections*, *6*(3), 229–241. https://doi.org/10.1080/23774657.2019.1641765

Reiner, R. (2007) *Law and Order: An Honest Citizen's Guide to Crime and Control.* Cambridge: Polity Press.

Renault, E. (2016) 'Critical theory and processual social ontology', *Journal of Social Ontology*, 2(1), pp. 17–32. https://doi.org/10.1515/jso-2015-0013

Revsbæk, L & Simpson, B (eds) 2022, *Doing Process Research in Organizations: Noticing Differently*. OUP. https://doi.org/10.1093/oso/9780192849632.001.0001

Reynolds V. (2016) 'Hate kills: A social justice response to suicide', in White, J., Marsh, I., Kral, M.J. and Morris, J. (eds) *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*. Vancouver: UBC Press, 169–187.

Richardson, M. and Schankweiler, K. (2019) 'Affective witnessing', *Affective Societies: Key Concepts*, pp. 166–177. doi: 10.4324/9781351039260-14.

Ricciardelli, R., Carleton, R. N., Anschuetz, B., Gravel, S., & McKay, B. (2022). Testifying after an Investigation: Shaping the Mental Health of Public Safety Personnel. *International journal of environmental research and public health*, 19(20), 13643. https://doi.org/10.3390/ijerph192013643

Ricciardelli, R., Easterbrook, B. and Turner, J. (2024) 'The Continuum of Moral Harms: Correctional Officers' Perspectives of Prison and the Influence on their Wellness', *Journal of Police and Criminal Psychology* [Preprint]. https://doi.org/10.1007/s11896-024-09659-w.

Ricciardelli, R., Idzikowski, M. and Pratt, K. (2020) 'Lives saved: Correctional officers' experiences in the prevention of prisoner death by suicide', 1(2), pp. 1–17. https://doi.org/10.1177/2632666320957855.

Ricciardelli, R., Pratt, K. and Idzikowski, M. (2021) 'Care, custody, control, and the preservation of life: the complexity of correctional officer work', *Journal of Crime and Justice*, 44(1), pp. 1–15. https://doi.org/10.1080/0735648X.2020.1759444.

Rivlin, A., Fazel, S., Marzano, L., & Hawton, K. (2011) 'The suicidal process in male prisoners making near-lethal suicide attempts', *Psychology, Crime & Law*, *19*(4), 305–327. https://doi.org/10.1080/1068316X.2011.631540

Robinson, G. (2022) 'Probation Work in the Juridical Field: A Dance to the Music of Time', in Carr, N. and Robinson, G. (eds.) *Time and Punishment.* Cham: Palgrave Macmillan, pp.203-225.

Romilly, C. and Bartlett, A. (2009) 'Prison Mental Health Care' in (eds.) A. Bartlett and G. McGauley, *Forensic Mental Health: Concepts, Systems and Practice.* Oxford: OUP.

Ross, M. W., Liebling, A. and Tait, S. (2011), 'The Relationships of Prison Climate to Health Service in Correctional Environments: Inmate Health Care Measurement, Satisfaction and Access in Prisons'. *The Howard Journal of Criminal Justice*, 50: 262-274. https://doi.org/10.1111/j.1468-2311.2011.00658.x

Roulston, A., McKeaveney, C., Anderson, M., McCloskey, P. and Butler, M. (2021) 'Deaths in Prison Custody: A Scoping Review of Experiences of Staff and Bereaved Relatives', *The British Journal of Social Work*, 51 (1), pp.223-245, https://doi.org/10.1093/bjsw/bcaa095

Rousseau, D.M., Sitkin, S. B., Burt, R.S. and Camerer, C. (1998) 'Not So Different After All: a cross-discipline view of Trust', *Academy of Management Review*, 23(3), pp. 393–404. https://doi.org/10.5465/amr.1998.926617

Royal College of Psychiatrists (2010) *Self-harm, suicide and risk: helping people who self-harm. CR158* Available: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr158.pdf?sfvrsn=fcf95b93_2

Ruck, S., Bowes, N. and Tehrani, N. (2013) 'Evaluating trauma debriefing within the UK prison service', *Journal of Forensic Practice*, 15(4), pp. 281–290. https://doi.org/10.1108/JFP-09-2012-0018

Rugulies, R. *et al.* (2023) 'Series Work and Health 2 Work-related causes of mental health conditions and interventions for their improvement in workplaces', *www.thelancet.com*, 402, p. 2023. https://doi.org/10.1016/S0140-6736(23)00869-3.

Samele, C., Urquia, N., Slade, K. and Forrester, A. (2017) 'Information pathways into prison mental health care'. *The Journal of Forensic Psychiatry & Psychology*, 28 (4), 548-561.

Sampath R. (2022) 'When Is Iatrogenic Harm Negligent?' *AMA J Ethics*, 1;24(8): E735-739. doi: 10.1001/amajethics.2022.735. PMID: 35976929.

Samuel, G. and Kitzinger, J. (2013) 'Reporting consciousness in coma: media framing of neuro-scientific research, hope, and the response of families with relatives in vegetative and minimally conscious states', *JOMEC Journal*, 0(3). https://doi.org/10.18573/j.2013.10244.

Saunders, K.E.A., Hawton, K., Fortune, S. and Farrell, S. (2012) 'Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review', *Journal of Affective Disorders*, 139(3), pp. 205–216. https://doi.org/10.1016/j.jad.2011.08.024.

Schaufeli, W. and Peeters, M. (2000) 'Job Stress and Burnout Among Correctional Officers', *International Journal of Stress Management*.

Scott, D. (2012) 'Creating ghosts in the penal machine', in Bennett, Crewe and Wahidin (Eds.), *Understanding Prison Staff.* Routledge: Abingdon.

Scott, D. (2018), *Against Imprisonment : An Anthology of Abolitionist Essays.* Waterside Press, Hook.

Séguin, M., Bordeleau, V., Drouin, M. S., Castelli-Dransart, D. A. and Giasson, F. (2014) 'Professionals' Reactions Following a Patient's Suicide: Review and Future Investigation', *Archives of Suicide Research*, *18*(4), 340–362. https://doi.org/10.1080/13811118.2013.833151

Sergi, V. and Hallin, A. (2011) 'Thick performances, not just thick descriptions: The processual nature of doing qualitative research', *Qualitative Research in Organizations and Management: An International Journal*, 6(2), 191–208.

Shafti, M., Steeg, S., de Beurs, D., Pratt, D., Forrester, A. and Taylor, P.J. (2022) 'The inter-connections between self-harm and aggressive behaviours: A general network analysis study of dual harm', *Frontiers in Psychiatry*, 13. doi: 10.3389/fpsyt.2022.953764.

Shaw, J., Baker, D., Hunt, I. M., Moloney, A. and Appleby, L. (2004) 'Suicide by prisoners national clinical survey', *The British Journal of Psychiatry*, 184(3), 263–267.

Shaw, S. (2017) *Independent Professional Advice on the Prevention of Self-Inflicted Deaths and Self-Harm at HMP Woodhill.* Report.

Sheard, L., Bellass, S., McLintock, K., Foy, R. and Canvin, K. (2023) 'Understanding the organisational influences on the quality of and access to primary care in English prisons: a qualitative interview study'. *British Journal of General Practice.* 73 (735): e 720-727.

Short, V., Cooper, J., Shaw, J., Kenning, C., Abel, K., Chew-Graham, C. (2009) 'Custody vs care: attitudes of prison staff to self-harm in women prisoners', *The Journal of Forensic Psychiatry & Psychology,* 20:3, 408-426. doi: 10.1080/14789940802377114.

Sim, J. (2021) '"Help me please": Death and self-harm in male prisons in England and Wales', *The Routledge International Handbook of Penal Abolition*, pp. 119–130.

Singh, S. and Wassenaar, D. (2016) 'Contextualising the role of the gatekeeper in social science research', *South African Journal of Bioethics and Law*, 9(1), p. 42. https://doi.org/10.7196/sajbl.2016.v9i1.465

Skinns, L., Rice, L., Sprawson, A., Wooff, A. (2017) 'Police legitimacy: an introduction', *Policing: An International Journal of Police Strategies & Management*, 40(3), 480–513.

Skinns, L., Sorsby, A. and Rice, L. (2020) '"Treat them as a human being": dignity in police detention and its implications for "good" police custody', *The British Journal of Criminology*, 1667–1688.

Slade, K., Scowcroft, L. and Dolan, B. (2019) *The impact of exposure to suicidal behaviour in institutional settings*. http://irep.ntu.ac.uk/id/eprint/36829/1/14046_Slade.pdf

Slade, K., Forrester, A. and Baguley, T. (2020) 'Coexisting violence and self-harm: Dual harm in an early-stage male prison population', *Legal and Criminological Psychology*, 25, pp. 182–198. doi: 10.1111/lcrp.12169.

Slade K. and Lopresti S. (2013) *Research Findings: Promoting Resilience in Prison Staff*. Nottingham Trent University. Available: http://irep.ntu.ac.uk/id/eprint/2343.

Smith, H. P., Power, J., Usher, A.M., Sitren, A. H., Slade, K. (2019) 'Working with prisoners who self-harm: A qualitative study on stress, denial of weakness, and encouraging resilience in a sample of correctional staff', *Criminal Behaviour and Mental Health*. 29(1), 7–17. doi: 10.1002/cbm.2103.

Snow, L. (2002) 'Prisoners' motives for self-injury and attempted suicide', *The British Journal of Forensic Practice*, 4(4), pp. 18–29. https://doi.org/10.1108/14636646200200023.

Snow, L. and McHugh, M. (2002) 'The aftermath of a death in prison custody', in Towl, G., Snow, L and McHugh, M. (eds.) *Suicide in prisons*. Oxford: BPS Blackwell.

Solnit, R. (2004) *Hope in the Dark: Untold Histories, Wild Possibilities*. New York: Nation Books. http://site.ebrary.com/id/11210884.

Spacey, A., Harvey, O. and Casey, C. (2020) 'Postgraduate researchers' experiences of accessing participants via gatekeepers: "wading through treacle!"', *Journal of Further and*

Higher Education, pp. 1–18. https://doi.org/10.1080/0309877X.2020.1774051/FORMAT/EPUB.

Sparks R., Bottoms, A. E. and Hay, W. (1996) *Prisons and the Problem of Order*. Oxford: Oxford University Press.

Spinaris, C. G., Denhof, M. D. and Kellaway, J. A. (2012) *Post Traumatic Stress Disorder in US Corrections Professionals: prevalence and impact on health and functioning.* National Institute of Corrections.

Steiner, B. and Meade, B., (2014) 'The safe prison', in Cullen, F.T., Jonson, C.L. and Stohr, M.K., (eds) *The American Prison*, London: Sage, pp 129– 150.

Steiner, B., & Wooldredge, J. (2015) 'Individual and Environmental Sources of Work Stress Among Prison Officers', *Criminal Justice and Behavior*, 42(8), 800-818. https://doi.org/10.1177/0093854814564463

Stephens, N. (2007) 'Collecting data from elites and ultra elites: Telephone and face-to-face interviews with macroeconomists', *Qualitative Research*, 7(2), 203–216.

St John-Smith, P., Michael, A. and Davies, T. (2009) 'Coping with a coroner's inquest: a psychiatrist's guide'', *Advances in Psychiatric Treatment*, 15, pp. 7-16

Stinglhamber, F., Nguyen, N., Josse, M and Demoulin, S. (2022) 'The Development of Prison Officers' Job Satisfaction and its Impact on Depersonalization of Incarcerated Persons: The Role of Organizational Dehumanization', *Criminal Justice and Behavior*, 49(11), pp. 1600–1617. doi: 10.1177/00938548221087182.

Sturge, G. (2024) *UK Prison Population Statistics,* House of Commons Library. https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf

Stürup-Toft, S., O'Moore, E.J. and Plugge, E.H. (2018) 'Looking behind the bars: emerging health issues for people in prison', *British Medical Bulletin*, 125, pp. 15–23. https://doi.org/10.1093/bmb/ldx052.

Sullivan, J. (2013) 'Flexible observations in the management of self-harm', *Mental Health Practice*, 16(10), pp. 32–37.

Suto, I. and Arnaut, G.L.Y. (2010) 'Suicide in Prison: A Qualitative Study', *The Prison Journal*, 90(3), pp. 288–312. https://doi.org/10.1177/0032885510373499.

Sweeney, F., Clarbour, J. and Oliver, A. (2018) 'Prison officers' experiences of working with adult male offenders who engage in suicide-related behaviour', *The Journal of Forensic Psychiatry & Psychology*. 29:3, 467-482

Sykes, G. (1958) *The Society of Captives: A Study of a Maximum Security Prison.* Princeton: Princeton University Press.

Tait, S. (2008) 'Care and the prison officer', *Prison Service Journal.* 3 (180), 3–11.

Tait, S. (2011) 'A typology of prison officer approaches to care'. *European Journal of Criminology,* 8, 440–454.

Tait, G., Carpenter, B., De Leo, D. and Tatz, C. (2015) 'Problems with the coronial determination of "suicide"', *Mortality*, 20(3), 233–247.

Taylor, D. (2009). Normativity and Normalization. *Foucault Studies*, (7), 45–63. https://doi.org/10.22439/fs.v0i7.2636

Taylor, D. (2014) 'Abnormal' in Lawlor, L. and Nale, J. (eds) *The Cambridge Foucault Lexicon.* Cambridge: CUP. https://doi.org/10.1017/CBO9781139022309

Teng, J. (2013) 'The Coroner's Court and nursing practice', *The Australian Nursing Journal*: ANJ. 21(1). https://search.informit.org/doi/10.3316/informit.396810311929503.

Thacker, H., Anka, A. and Penhale, B., (2019) 'Could curiosity save lives? An exploration into the value of employing professional curiosity and partnership work in safeguarding adults under the Care Act 2014', *The Journal of Adult Protection*, *21*(5), pp.252-267.

The Howard League and the Centre for Mental Health (2017) *Preventing Prison Suicide: staff perspectives*. Available: https://howardleague.org/wp-content/uploads/2017/02/Preventing-prison-suicide.-Staff-perspectives.pdf

The Howard League (2024) *Prisons information.* https://howardleague.org/prisons-information/

The King's Fund (2024) *NHS Workforce in a Nutshell* https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell

The Red Hand Files (2022), *Do you still Believe in us?* https://www.theredhandfiles.com/do-you-still-believe-in-us/

Thompson, S. (2017) 'Old age and assaults on the self: A disenfranchised form of trauma?'. in *Handbook of Traumatic Loss* (pp. 91-106). New York: Routledge.

Thompson, N., and Doka, K. J. (2017) 'Disenfranchised grief', in Thompson, N. and Cox, G. R. (eds.) *Handbook of the sociology of death, grief, and bereavement,* 177–190. London: Taylor and Francis.

Tomczak, P. (2014) *Punishment and Charity: conceptualising the penal voluntary sector in England and Wales*. PhD Thesis. University of Manchester.

Tomczak, P. (2018) *Prison suicide*: *what happens afterwards?* Bristol: Bristol University Press.

Tomczak, P. (2022a) 'Reconceptualizing multisectoral prison regulation: Voluntary organizations and bereaved families as regulators', *Theoretical Criminology*, 26(3), 494-514. https://doi.org/10.1177/1362480621989264

Tomczak P (2022b) 'Highlighting "Risky Remands" through prisoner death investigations', *Frontiers in Psychiatry* 13(862365): 1–12.

Tomczak, P. and McAllister, S. (2021) 'Prisoner death investigations: a means for improving safety in prisons and societies?', *Journal of Social Welfare and Family Law*, 43(2), pp. 212–230. https://doi.org/10.1080/09649069.2021.1917714.

Tomczak, P., Quinn, K., Traynor, C. and Wainwright, L. (2023) '(Re)constructing Prisoner Death Investigations: A Case Study of Suicide Investigations from England and Wales', *Law & Social Inquiry*, *49*(3), 1842–1876. doi:10.1017/lsi.2023.75

Towl, G. and Crighton, D. (2017) *Suicide in Prisons: Prisoners' Lives Matter*. Waterside Press

Trier-Bieniek, A. (2012) 'Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion', *Qualitative Research*, *12*(6), 630-644. https://doi.org/10.1177/1468794112439005

UNODC & WHO (2013) *Good Governance for prison health in the 21st century*. Copenhagen: WHO. Available: https://iris.who.int/bitstream/handle/10665/326388/9789289000505-eng.pdf?sequence=1

Valentine, C. (2007) 'Methodological Reflections: Attending and Tending to the Role of the Researcher in the Construction of Bereavement Narratives', *Qualitative Social Work*, 6(2), pp. 159–176.

Van Bogaert, P., Clarke, S., Willems, R. and Mondelaers, M. (2012) 'Nurse practice environment, workload, burnout, job outcomes, and quality of care in psychiatric hospitals:

a structural equation model approach'. *Journal of Advanced Nursing*. 69(7): 1515-1524. doi:10.1111/jan.12010.

van Dellen, A. *et al.* (2022) 'What the psychiatrist needs to know about the coroner's court in England and Wales', *BJPsych Advances*, 28(3), pp. 187–194. https://doi.org/10.1192/bja.2021.70.

Van Hooft, S. (2011) *Hope.* Durham: Acumen Publishing.

Völlm and Clarke (2018) *Secure Hospital Care: information for carers.* Nottingham: Institute for Mental Health.

Wacquant, L. (2009a) *Prisons of Poverty*, Minneapolis, MN.: University of Minnesota Press.

Wacquant, L. (2009b) *Punishing the poor: The neoliberal government of social insecurity*. Durham: Duke University Press.

Walker, T., Shaw, J., Hamilton, L. Turpin, C., Reid, C. and Abel, K. (2016) 'Supporting imprisoned women who self-harm: exploring prison staff strategies', *Journal of Criminal Psychology*, 6(4), pp. 173–186. https://doi.org/10.1108/JCP-02-2016-0007.

Walker, T., Shaw, J., Hamilton, L., Turpin, C., Reid, C., Abel, K. (2017) '"Coping with the job": prison staff responding to self-harm in three English female prisons: a qualitative study', *Journal of Forensic Psychiatry and Psychology*, 28(6), 811–824. https://doi.org/10.1080/14789949.2017.1331369

Walker, T. and Towl, G. (2016) *Preventing Self-injury and Suicide in Women's Prisons*. London: Waterside Press.

Walsh, E. (2009) 'The emotional labor of nurses working in her Majesty's (HM) prison service', *Journal of Forensic Nursing*, 5(3), pp. 143–152. https://doi.org/10.1111/J.1939-3938.2009.01047.X.

Walsh, L. (2022) *Malignant Alienation: What is it, and what can we do about it?* Conference presentation.

Wang, C. (2019) 'Temporal dynamics in the daily lives of health practitioners', *Time & Society*, 28(4), 1552-1576. https://doi.org/10.1177/0961463X18787047

Warr, J. (2020) *Forensic Psychologists: prisons, power and vulnerability.* Bingley: Emerald Publishing.

Warr, J. (2022) 'Whitening Black Men: Narrative Labour and the Scriptural Economics of Risk and Rehabilitation', *The British Journal of Criminology*, pp. 1–17. https://doi.org/10.1093/bjc/azac066.

Watson, C., Husband, G. and Ireland, A. (2021) 'Opening the "black box": what does observational research reveal about processes and practices of governing?', *Journal of Management and Governance*, 25, pp. 189–221. https://doi.org/10.1007/s10997-020-09503-3.

Watts, D. and Morgan, G. (1994) 'Malignant Alienation Dangers for patients who are hard to like', *British Journal of Psychiatry*, 164. https://doi.org/10.1192/bjp.164.1.11.

Webber-Ritchey, K.J., Simonovich, S.D. and Spurlark, R.S. (2021) 'COVID-19: Qualitative Research with Vulnerable Populations', *Nursing Science Quarterly*, 34(1), pp. 13–19. https://doi.org/10.1177/0894318420965225.

Weber, M. (1905, 1976) *The Protestant ethic and the spirit of capitalism,* T. Parsons (Trans.). NY: Scribner.

Wheatcroft, J.M., Alison, L.A. and McGrory, D. (2012) 'The Influence of Trust on Senior Investigating Officers' Decision Making in High-Profile Critical Incidents', *Police Quarterly*, 15(4), pp. 386–413. https://doi.org/10.1177/1098611112447610.

Whitehead, A. N. (1929) *Process and reality: An essay in cosmology*. New York: Free Press.

Whitehead, P.R. (2012) 'The lived experience of physicians dealing with patient death', *BMJ Supportive & Palliative Care*, (4), pp. 271–276 https://doi.org/10.1136/bmjspcare-2012-000326.

Whitter, A. (2021) 'Patient suicide: why nurses need colleagues' support to grieve', *Mental Health Practice*, 24(2), pp. 13–14. https://doi.org/10.7748/MHP.24.2.13.S5.

Whittle, M. (1997) 'Malignant alienation', *Journal of Forensic Psychiatry*, 8(1), pp. 5–10. doi: 10.1080/09585189708411990.

Wildeman, C. and Wang, E.A. (2017) 'Mass incarceration, public health, and widening inequality in the USA', *The Lancet*, pp. 1464–1474 https://doi.org/10.1016/S0140-6736(17)30259-3.

Wilkerson, J.M., Iantaffi, A., Grey, J.A., Bockting, W.,O. and Rosser, B.R.S. (2014) 'Recommendations for Internet-Based Qualitative Health Research With Hard-to-Reach Populations', *Qualitative Health Research*. 24(4): 561-574. doi:10.1177/1049732314524635.

Wilkinson, S., & Kitzinger, C. (2013) 'Representing Our Own Experience: Issues in "Insider" Research', *Psychology of Women Quarterly*, *37*(2), 251-255. https://doi.org/10.1177/0361684313483111

Williams, P. (2018) *Prison health Twelfth Report of Session 2017-19 Report, together with formal minutes relating to the report Health and Social Care Committee*. London: House of Commons. https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf

Williamson V., Stevelink, S. A. M. and Greenberg N. (2018) 'Occupational moral injury and mental health: systematic review and meta-analysis'. *Br J Psychiatry*. 212: 339–46

Williamson, V., Murphy, D., Phelps, A., Forbes, D. and Greenberg, N. (2021) 'Moral injury: the effect on mental health and implications for treatment' *The Lancet Psychiatry,* 8 (6), pp. 453-455. https://doi.org/10.1016/S2215-0366(21)00113-9.

Wilstrand, C., Lindgren, B.M., Gilje, F. and Olofsson, B. (2007) 'Being burdened and balancing boundaries: A qualitative study of nurses' experiences caring for patients who self-harm', *Journal of Psychiatric and Mental Health Nursing*, 14(1), pp. 72–78. https://doi.org/10.1111/j.1365-2850.2007.01045.x.

Woods, L., Craster, L. and Forrester, A. (2020) 'Mental Health Act transfers from prison to psychiatric hospital over a six-year period in a region of England', *Journal of Criminal Psychology*, 10 (3): 219-231. https://doi.org/10.1108/JCP-03-2020-0013

Wright, L., Borrill, J., Teers, R., & Cassidy, T. (2006) 'The mental health consequences of dealing with self-inflicted death in custody', *Counselling Psychology Quarter*ly, 19(2), 165-180.

Wright, N., Tompkins, C.N.E. and Mohammed, Z. (2012) 'Cross examination of clinicians at coroners' inquests following deaths in custody', *International Journal of Prisoner Health*, 8 (3/4), pp. 92-98. https://doi.org/10.1108/17449201211284969

Wurst, F.M., Kunz, I., Skipper, G., Wolfersdorf, M., Beine, K.H. and Thon, N. (2011) 'The therapist's reaction to a patient's suicide: Results of a survey and implications for health care professionals' well-being', *Crisis*, 32(2), pp. 99–105. https://doi.org/10.1027/0227-5910/a000062.

Xenakis, S., & Cheliotis, L. K. (2019) 'Whither neoliberal penality? The past, present and future of imprisonment in the US'. *Punishment & Society*, 21(2), 187-206. https://doi.org/10.1177/1462474517751911

Zhong, S., Senior, M., Yu, R., Perry, A., Hawton, K., Shaw, J., Fazel S. (2021) ‘Risk factors for suicide in prisons: a systematic review and meta-analysis’, *The Lancet Public Health*. 6 (3), e164–e174.

Appendices:

1. Participant characteristics
2. Interview schedules
3. Researcher reflection questions
4. Participant Information Sheet
5. Participant consent and GDPR form
6. Participant distress protocol

Appendix 1: Participant characteristics

Cohort	Pseudonym	Role(s)	**Prison work tenure** (years)
A	Rumi	Former prison counsellor	10<
A	Bobby	Former prison psychotherapist	10<
B	Alex	Senior prison health expert and prison doctor	10<
A	Ashley	Former RMN and senior healthcare manager	5-10
A	Riley	Former RGN and senior healthcare manager	5-10
A	Jean	Former prison psychiatrist	5-10
A	Casey	Former head of healthcare	5-10
A	Charlie	Former RGN	5-10
C	Chris	Former nurse; senior health and justice manager	10<
C	Sasha	Senior health and justice manager	5-10
C	Max	Former RMH nurse; senior health and justice lead	5-10
C	Taylor	Senior health and justice staff	5-10
B	Sheridan	Range of senior national health and justice roles, past and present	10<
A	Frankie	Former prison psychologist	2-5
B	Lee	Senior prison health expert and prison doctor	10<
C	Lesley	Former RMH; senior national health and justice manager	2-5
A	Fin	Former RGN, Head of Healthcare and Regional Operations Manager	10<
C	Drew	Former prison doctor; national manager, prison health	10<
A	Mel	Former RGN, head of healthcare and national health and justice role	10<

B	Kerry	Former prison doctor; senior national role, health and justice	10<
B	Rene	Senior national role, health and justice	10<
B	Hilary	Senior national role, health and justice	5-10
A	Hayden	Former prison nurse/healthcare officer	10<
A	Jude	Former healthcare support worker	>2
C	Gurpreet	Senior national director, health and justice	2-5
A	Sullivan	Former frontline VCS healthcare worker	5-10
A	Morgan	Former RGN	2-5
A	Sammy	Former prison psychologist	2-5

Cohort A: former prison healthcare staff who have left prison work.

Cohort B: specialist knowledge stakeholders.

Cohort C: senior managers in prison healthcare (public, private and third sector).

Work tenure has been categorised (>2 years, 2-5 years, 5-10 years, 10< years) for confidentiality.

RGN – registered general nurse.

RMH – registered mental health nurse.

VCS – voluntary and community sector.

Appendix 2: Interview schedule

Interview Structure for Cohort 1, former prison healthcare workers.

Content	Timing

Welcome and introduction
- I'm Sara, thanks for giving your time to do this
- Would you like to have your camera on or off for our conversation? I'll only make an audio recording of the interview however.
- Permission to record? START RECORDING
- Confirm consent form received (if not consent form received, ask if they can email form now. If not possible for form to be emailed, Sara read aloud and take point by point verbal consent form participant)
- Remind participant:
  - this is audio only, held securely, transcribed by automated transcription service, confidential interview
  - there are no right or wrong answers and that they can chose how to answer any question posed
  - we can pause or stop the interview at any time
- If there is any disclosure of intended harm to self or others, at the conclusion of the interview, the researcher will discuss possible onward with referral with you.
 	
- I'm Sara Hyde, I've worked in and around prisons for over a decade and now I'm a prison researcher and PhD student at University of Nottingham. I'm not connected to the NHS or HMPPS in any way.
	5 mins

Content	Timing
- Your participation in and responses given during this research are confidential, as laid out in the Participant Information Sheet. - Thank you for agreeing to take part, let's begin!	
Scene setting questions/prompts • How long did you work in prison health for? • What kinds of roles did you have? (Additional prompts: how long for? In which settings – male/female; category and type of prison?) • What reasons did you have for working in *prison* healthcare? (Prompts: pragmatic, job market, special interest)	5 mins
The job itself questions/prompts • When thinking about your final prison healthcare role, what words come to mind? Why? • What did you enjoy most? • What kind of training did you receive about suicide or self-harm? **The challenges questions/prompts** • What were some of the more challenging aspects of the role? (prompt if necessary) What were the challenging aspects of the setting? • What were your strategies for managing those challenges? • What kind of support did you draw on to support you with those challenges? (prompt if necessary: peer, home, management, EAP/formal support in work)	10 mins

Content	Timing
• If not covered: how did you and your peers work to overcome challenges? How did you find challenging times effecting home life or vice versa? Have you ever used support offered by management or prison support systems? • What led to you deciding to leave prison healthcare work? (explore/prompt fully – can you tell me a bit more about that? Why was that? Ok, anything else you think I need to understand about that?) [Must ask this question]	
Exposure to self-harm *Interviewer: In this next section, I'd like to understand a bit more about your experiences with self-harm and suicide specifically.* • When you worked in prison healthcare, how often did you encounter self-harm? • How did you approach working with those who self-harmed? Was this any different when it was someone who repeatedly self-harmed? • Are there any incidents of self-harm that have stayed with you? Do you have a sense of why? • What support did you receive at the time? Have you accessed any support since? What support would you like to have received? • How did your peers manage the impacts on prisoner self-harm on themselves? How did you manage them on yourself? • Looking back, how would you describe the experience of working with prisoners who self-harm?	10 mins

Content	Timing
Exposure to suicide • Can you tell me about any direct or indirect involvement you had with any suicides or near misses in prison? Prompts: were they frequent? What was your level of involvement? • Were you able to access any kind of support at the time? Have you accessed any support since? What support would you like to have received? • How did your peers manage the impacts of prisoner suicide and suicide attempts on themselves? How did you manage them on yourself? (as relevant) • Were you involved in the PPO investigation? Can you tell me about that experience? • Did you have to go to court for the inquest? How would you describe this experience? • What changes did the prison or healthcare team make because of that death? • What do you think the ingredients of a good response are? (Prompts: who does it involve? How long does it go on for? Did you ever see a good response?) • Looking back, how would you describe the experience of working with prisoner suicide and attempted suicide?	10 mins
Summarising questions/prompts • What advice would you give people still working in prison healthcare re: prisoner suicide and self-harm?	10 mins

Content	Timing
• What do you wish the average person on the street knew about prisoner suicide and self-harm? • Do you think working in prison healthcare has changed you? If so, how? • If you had a magic wand and could change your life at work and that of your colleagues, what would you change?	
Wrap up questions/prompts • Is there anything else you think it's important that I know that you haven't had the opportunity to mention yet? • How have you found the experience of being interviewed today? • Do you have any questions for me? **Thank and close** • Reminder of confidentiality, discussion of any additional support for participant and any onward referral • Reminder that immediately following the interview, Sara will email the post-interview support sheet numbers • Thank participant for their time and close.	5 mins

Appendix 3: Researcher reflection questions

How did the interview run? How was the rapport?

What are the salient points of the interview?

Did you feel or remember feeling anything particularly acutely at any point in the interview?

Was any moment particularly striking, memorable or unusual?

Anything else of note that may not get picked up by the transcription?

Anything else you want to note about your experience of the interview as a human being and a researcher?

Appendix 4: Participant Information and GDPR Sheet

Participant Information Sheet & GDPR Privacy Notice

Section 1 - Participant Information Sheet

Date: January 2022

Title of Study: Prison healthcare staff: transformative potential for safety and health in prisons?

Name of Researcher(s): Sara Hyde

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

Prison rates of suicide and self-harm over the last few years have reached all-time highs. Prison staff are carrying out their work in this context and prison healthcare staff are trying to deliver healthcare within it. Prison healthcare staff are an overlooked and an important part of changing this and improving prison health and safety. This study seeks to explore the experiences of prison healthcare staff of both prisoner suicide and self-harm, as well as considering the impacts on them.

Why have I been invited?

You are being invited to take part because you [delete one – are a former prison healthcare worker/ have specialist knowledge relating to prison healthcare and/or suicide and self-harm. We are inviting [delete one - 14/ 7] participants like you to take part.

Please note, prison healthcare workers include: primary healthcare workers, mental health staff, voluntary sector organisations, agency or bank staff, specialist staff such as dentists or substance misuse nurses, staff of any grade or banding within healthcare.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

[Delete one – cohort one option /cohort two option]

Cohort one – former prison healthcare staff

We will talk about your work in prison healthcare for between 45 and 60 minutes, via MS Teams (or telephone), you can choose to have the camera on or off but the recording made will be audio only. This will include talking about your experiences of prisoner suicide and self-harm. You can tell me as much or as little as you want to about your experiences and opinions. I will not attribute anything you tell me directly to you. The findings of these interviews will feed in to my PhD thesis, which is funded by the University of Nottingham.

Or

Cohort two – specialist knowledge stakeholders

We will talk about your role in connection to prison healthcare and/or prisoner suicide and self-harm for between 45 and 60 minutes, via MS Teams (or telephone), you can choose to have the camera on or off but the recording made will be audio only. This will include talking about your opinions on prison healthcare staff experience of prisoner suicide and self-harm. You can tell me as much or as little as you want to about the subject matter. I will not attribute anything you tell me directly to you. The findings of these interviews will feed in to my PhD thesis, which is funded by the University of Nottingham.

[For both cohorts]

In the unlikely event of the disclosure of harm to self (or others), the researcher may pass on information to appropriate authorities or colleagues to avoid harm to you (or others): this would be done following discussion with you. The researcher will also report any disclosure of harm to her supervisors and refer to the School of Sociology and Social Policy Research Integrity and Ethics Committee Chair for discussion about any possible University of Nottingham requirements or reporting.

All participants will be provided with a sheet detailing sources of support at the end of the interview.

Expenses and payments

Participants will not be paid an allowance to participate in the study.

What are the possible disadvantages and risks of taking part?

You will give up to an hour of your time. The interview covers the topics of prison suicide and self-harm and the impacts of them. This may be distressing to you. If you become distressed and do not wish to continue participating, the interview can be paused or terminated at any time. There is very little data at the moment about healthcare staff experiences and a better understanding matters in the pursuit of safer prisons.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help understand the experiences of healthcare staff in prisons regarding suicide and self-harm. This is turn may enable better policy and practice to reduce rates of suicide and self-harm.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the School Research Ethics Officer. All contact details are given at the end of this information sheet.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

Your interview will be transcribed using the University of Nottingham Automated Transcription Service. The service complies with GDPR provisions where it is used as part of good research practice. Whilst data is being processed (after uploading the audio and before downloading the transcripts) it is being stored and handled within Microsoft Azure. Azure is audited annually for compliance with ISO/IEC 27001 - a widely recognised industry standard for secure data handling.

If you join the study, the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research - Sara Hyde, Dr Philippa Tomczak and Dr Melanie Jordan. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. Confidentiality means not disclosing identifiable information about individuals collected during the process of research, and when sharing research findings, that these are presented in ways that mean participants cannot be identified.

All information which is collected about you during the research will be kept **strictly confidential**, secured within the University of Nottingham. Any information about you which leaves the University will have your name and email address removed (anonymised) and a unique code will be used so that you cannot be recognised from it. Anonymised data may also be stored in data archives for future researchers interested in this area.

Your personal data (email address and/or telephone number) will be kept for seven years after the end of the study so that we are able to contact you about the findings of the study *and possible follow-up studies* (unless you advise us that you do not wish to be contacted). All identifiable research data will be kept securely for seven years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw the information collected so far may not be possible to extract and erase after June 2022 and this information may still be used in the project analysis.

What will happen to the results of the research study?

The data collected in interview will be analysed and written up in to a PhD. Some of the findings may be written up into articles for publication or presented at conferences. You will not be identified in any publication or presentation. University of Nottingham PhD theses are held in an open access online repository.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?

All research in the University of Nottingham is looked at by a group of people, called a Research Ethics Committee (REC), to protect your interests. This study has received a Favourable Ethical Opinion by the School of Sociology and Social Policy Research Ethics Committee.

Further information and contact details

Researcher: Sara Hyde, sara.hyde1@nottingham.ac.uk

Supervisor/PI: Dr Philippa Tomczak, Philippa.tomczak@nottingham.ac.uk

Dr Melanie Jordan, Research Ethics & Integrity Officer, REC Chair & Associate Professor in Criminology. email: melanie.jordan@nottingham.ac.uk, +44 (0)115 74 87284/ 95 15410

Section 2 - **Privacy information for Research Participants**

For information about the University's obligations with respect to your data, who you can get in touch with and your rights as a data subject, please visit: https://www.nottingham.ac.uk/utilities/privacy.aspx.

Why we collect your personal data

We collect personal data under the terms of the University's Royal Charter in our capacity as a teaching and research body to advance education and learning. Specific purposes for data collection on this occasion are to analyse the data collected to understand more about healthcare staff experiences of prison suicide and self-harm, then writing this up into a PhD, articles and conference papers to influence policy and practice.

Legal basis for processing your personal data under GDPR

The legal basis for processing your personal data on this occasion is Article 6(1a) consent of the data subject.

Special category personal data

In addition to the legal basis for processing your personal data, the University must meet a further basis when processing any special category data, including: personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation.

The basis for processing your sensitive personal data on this occasion is Article 9(2a) the data subject has given explicit consent to the processing.

How long we keep your data

The University may store your identifiable research data for a minimum period of seven years after the research project finishes. The researchers who gathered or processed the data may also store the data indefinitely and reuse it in future research. Measures to

safeguard your stored data include: only storing study materials on password protected University of Nottingham OneDrive IT account; only allowing the researcher and supervisors to access pseudonymisation matrix; deletion of audio recordings following transcription; removing any identifying names, place names or other features from the transcripts at the earliest possible stage.

Who we share your data with

Extracts of your data may be disclosed in published works that are posted online for use by the scientific community. Your data may also be stored indefinitely on external data repositories (e.g., the UK Data Archive) and be further processed for archiving purposes in the public interest, or for historical, scientific or statistical purposes. It may also move with the researcher who collected your data to another institution in the future.

Appendix 5: Participant consent form

School of Sociology and Social Policy

Participant Consent Form

Name of Study: Prison healthcare staff: transformative potential for safety and health in prisons?

Name of Researcher(s): Sara Hyde

Name of Participant:

By signing this form I confirm that (please initial the appropriate boxes)**:**	**Initials**
I have read and understood the Participant Information Sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time, without having to give a reason.	
My participation in the study and responses will be treated confidentially.	
Taking part in this study involves an interview that will be recorded using audio recording. This recording will then be transcribed using the University of Nottingham Automated Transcription Service. Once transcribed, the recording will be destroyed.	
I consent to the researcher writing a short, reflective note about the interview to be kept confidentially and also to be included as data to be analysed.	
If I disclose intended harm to myself (or others), I consent to the researcher discussing this with me at the conclusion of the interview and	

possibly passing information to appropriate authorities or colleagues to avoid harm to me (or others).	
Personal information collected about me that can identify me, such as my name or where I live or work(ed), will not be shared beyond the study team.	
My words can be quoted in publications, reports, web pages and other research outputs.	
I give permission for the de-identified (anonymised) data that I provide to be used for future research and learning.	

I agree to take part in the study

_____ _____ _____

Name of Participant Signature Date

_____ _____ _____

Researcher's name Signature Date

Appendix 6: Participant distress protocol

Title: Prison healthcare staff: transformative potential for safety and health in prisons?

This protocol is based on the steps outlined in the Nicholson Distress Protocol 1, the protocol for managing participant distress in the context of a research interview. The define participant distress as 'a participant indicating that they are experiencing distress' or that they 'exhibit behaviours suggestive that the interview is causing distress; for example, crying, shaking, agitation'.

This proposed study is not being undertaken with a vulnerable group of patients or prisoners. It is being undertaken with staff and former staff, who have capacity and with their full consent. As such they lack the vulnerabilities that may need to be considered with a different patient cohort but they may still experience distress as a result of participation in the interview.

At the start of the interview, the participant will be reminded that it is entirely up to them how they chose to answer the questions and direct the flow of conversation. The interviews are being conducted by MS Teams and the participant can chose to keep their camera on or off; for those who leave the camera on, the principal investigator (PI) will have also have visual cues available to detect any emerging distress. At any point during the interview, should the participant become distressed, the PI will make the offer to pause the interview. If the interview is paused, the PI will then check with the participant before resuming that they feel comfortable and safe in resuming the interview. If they do the PI will continue the interview (in line with stage 1 and review steps in Nicholson Protocol). If they do not, the PI will terminate the interview and follow guidance outlined here for distress at the closure of interview (stage 2 step in Nicholson Protocol).

At the close of the interview, should a participant be distressed, they will be asked if they want the PI to inform anyone else. For all participants, the PI will ask at the end of the interview, how they found the experience of being interviewed and respond accordingly. All participants are emailed a support sheet on completion of the interview. In the event that

the participant remains distressed, the PI will explore with them what support they have at work or at home to enlist on that day.

If any interview requires pausing or terminating, the PI will notify her supervisors and discuss it at the next supervision or at the earliest opportunity, as appropriate to the severity of the participant's distress.

In the unlikely event of the disclosure of harm to self (or others), the researcher may pass on information to appropriate authorities or colleagues to avoid harm to the participant (or others), following discussion with the participant. The researcher will also report any disclosure of harm to her supervisors and refer to the School of Sociology and Social Policy Research Integrity and Ethics Committee Chair for discussion about any possible UoN requirements or reporting.