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End-of Life Care and Barriers for Female Inmates

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Abstract

The number of female inmates is growing, and their average age is increasing. As a result, end-of-life care is situated in a highly restrictive environment with a focus on security rather than comfort. We describe the need for and potential barriers to humane care and provide care strategies that can be useful in a complex organizational system. Frontline workers such as nurses who understand the balance between care and control must promote change in the women's prison system.

Keywords

dying; end-of-life; inmates; prison; prisoners; women

Women comprise a steadily growing number and percentage of inmates in the state and federal prison population. In fact, in the eight years preceeding 2008, the Bureau of Justice Statistics (2009) reported a 33% increase in the number of women incarcerated across the United States. Despite the fact that women often are incarcerated for nonviolent crimes such as drugs or commercial sex work, the rate of violent crimes is increasing among women. Overall harsher sentencing due to "get tough on crime" legislation and fewer inmates being released on parole have resulted in increasing numbers of female offenders aging and eventually dying in prison (Mauer, Potler, & Wolf, 1999). Growing numbers of old and dying inmates are becoming a national crisis in the American correctional system; however, this crisis has received little attention (Enders, 2004). Correctional health care budgets are strained and a myriad of challenges exist when dealing with older, sicker, and dying inmates. Nurses have a long-standing history of providing compassionate care to support patients dying with dignity. However, in 2003 Granse described compassionate care in

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prison as an oxymoron. Based on available literature and exploratory field work, the purpose of this paper is to highlight the needs of women nearing the end of life (EOL) in prison and potential barriers to humane EOL care.

Women's prisons are unique organizations; they are few in number and typically serve a wide range of needs (e.g., severely mentally ill inmates, geriatric inmates, physically disabled inmates, along with younger more vigorous inmates) and security levels (minimum, medium, close, and maximum security) (see Table 1). Various health care delivery issues exist within the current system. Women are often processed and housed in one facility for their entire sentences, regardless of their need for disease treatments such as for AIDS, (Belenko, Shedlin, & Chaple, 2005), end-stage renal disease, cancer treatments, or hepatitis C, and prenatal care. Specialized facilities are not available for the large percentage of female inmates who have psychiatric problems. Due to the limited transfer of inmates between women's prisons, a strong community of inmates is formed. When one of the community members dies, the community experiences the loss collectively (Fisher & Hatton, 2009). The rising number of female inmates is further complicated by the increasing age of the population. These trends have negatively affected the current capacity of women's prisons leading to over-crowded facilities that do not accommodate the aging, physically challenged women. The rising population also creates increased demands for other services such as dispensary (i.e., outpatient clinic) and infirmary (i.e., inpatient unit) care. Collectively, these facility limitations are compounded by women who require EOL care.

CALLOUT 1

Prison Deaths

A review of how most women die in prison is a crucial first step toward understanding why there is a growing need for EOL prison care. Since 1976 only 11 female inmates have died from sanctioned executions in the United States (Death Penalty Information Center, 2010). Stereotypical images in the popular media promote a perception that prison death is due to suicide or homicide by fellow inmates. In reality, execution, homicide, and suicide combined account for less than one fourth of all prison deaths. The vast majority of deaths in U.S. prisons are a result of natural causes (American Correctional Association, 2007), and the leading causes are chronic, debilitating diseases, with heart disease, cancer, and liver disease the top three for women, followed by AIDS, suicide, septicemia, respiratory diseases, cerebrovascular diseases, influenza/pneumonia, and digestive diseases. AIDS continues to be an significant cause of death among female inmates for three key reasons: engagement in commercial sex work (Fogel & Belyea, 1999); late diagnosis that increases the likelihood the virus will progress to AIDS (Holstad, Dilorio, & Magowe, 2006); and lack of medical privacy promoting stigma that results in non-adherence to antiretroviral therapy (Roberson, White, & Fogel, 2009; Lewis, Colbert, Erlen, & Meyers, 2006). Lung cancer is responsible for the largest number of cancer deaths, with breast and colon cancers ranked second and third respectively. Gender-specific cancer (e.g., breast, ovarian, cervical, and uterine) were responsible for nearly one fourth (24%) of all cancer deaths among female inmates (Mumola, 2007).

CALLOUTS

1. Increasing numbers of female offenders are aging and eventually dying in settings with barriers to the delivery of humane end-of-life care.

Research on Women and EOL Care during Incarceration

The aging population of female inmates coupled with the prevalence of chronic illness strongly suggest a need to understand EOL care, yet scant empirical literature is available. Using key search terms including dying, end-of-life, hospice, palliative care, prison, and prisoner, a search of the nursing and allied health (CINAHL), medical (PubMed), and criminal justice literature (Criminal Justice Abstracts) for all dates through March 2010 resulted in only three English language research articles relevant to female inmates and EOL (Deaton et al., 2009–2010; Enders, et al., 2005; Zimmermann, Wald, & Thompson, 2002).

Zimmermann et al. (2002) explored the needs and resources for hospice care in 212 Connecticut prison inmates of whom 54% (n=115) were women. More than half of the female inmate participants had been homeless at some time, a finding with implications when planning for compassionate release or early release due to special circumstances for terminally ill inmates. In this sample, higher rates of psychiatric disorders and HIV infection were both associated with female inmates. When the researchers inquired about inmates' preferences regarding terminal care they found that although inmates did not wish to receive terminal care in prison they were generally satisfied with prior care from correctional health professionals. In fact, 73% of the inmates reported that the care they received from corrections healthcare was at least satisfactory (Zimmermann et al.). When questioned about familiarity with and responsiveness to hospice care, female inmates were significantly more likely to have heard of hospice care and to be receptive to using hospice care in prison. The overwhelming majority of all inmate participants (84%) preferred that hospice care be provided by hospice staff from outside of prison rather than corrections' staff trained to provide hospice care. Ninety-one percent of the female inmates reported they would become a hospice peer volunteer and 84% wanted support from an inmate peer volunteer should the need arise (Zimmermann et al.).

In contrast, the findings of Enders et al. (2005) were translated into practice. The researchers conducted focus groups with 113 female inmate participants to explore informational barriers related to making medical treatment and EOL care decisions. The primary barriers to effective decision-making identified by the inmates included visit time limitations and physician practice that focused only on one problem per visit. The development of trusting relationships with physicians was compromised by a lack of continuity in health care providers from one visit to the next. In addition, experiences with prison health care providers were characterized by feelings of helplessness, intimidation, shame, guilt, and embarrassment. In short, participants felt ill equipped to advocate for themselves and had no confidence that their physician would advocate on their behalf. The inmate participants also expressed fear of their lack of knowledge and confidence in making decisions regarding EOL care if they were to die in prison. The female inmates suggested that the EOL information be written in simple language with eye-catching graphics to help them to learn how to communicate more effectively. From their findings, the researchers developed a handbook, called *Choosing Healthcare Options through Information, Communication, and Education*. The primary focus of the handbook was to provide resources to build the confidence of inmates in health care decision making by breaking down barriers and facilitating better inmate patient-physician experiences (Enders, 2004; Enders et al., 2005).

Deaton et al., 2009–2010 explored the relationship between death anxiety and numerous health variables using a descriptive correlational design. Female inmates (N=327) aged 50 and older from five southern U.S. states completed self-administered surveys. These participants had substantially greater death anxiety, as measured on the Templar Death Anxiety Scale, than was typical of their non-incarcerated counterparts. Over two-thirds of female inmates reported a preoccupation with death, a variable found to be significantly

linked with death anxiety. The incarcerated women shared examples of harm that occurred within the prison healthcare system. For example, harm was attributed to incidents of indifference to the inmates' health needs and care that lacked compassion and humanity. Observations of other inmates receiving substandard care at the EOL (e.g., denial or delaying of care) also contributed to participants' anxieties about dying in prison as did worries about experiencing pain and indignity during the dying process. In fact, the process of dying was much more feared than death itself. Female inmates distrusted the prison health care system and perceived it as highly defective (Deaton et al., 2009–2010).

CALLOUT 2

Barriers to EOL Care Revealed through Non-Research Literature and Field Work

Several relevant theoretical, clinical, and opinion articles, book chapters, books, and field work by the research team (authors of this manuscript) described potential barriers to humane EOL care in prisons, one of which is the balance between conflicting priorities of caring for patients and ensuring security experienced by correctional health care employees. An example of this conflict is seen when some staff become cynical and interpret any inmate's politeness as a form of manipulation or scamming. This phenomenon is described by Maeve and Vaughn (2001) as contributing to the penal harm movement (i.e., increasing the misery bestowed upon inmates). Concerns that inmates are "gaming for drugs" (i.e., pretending to be in pain to obtain narcotics) can be a barrier to adequate pain control for dying inmates; health care professionals may withhold administration of narcotics, believing that inmates are feigning pain to obtain drugs to support their addictions.

Just as prison health care providers may distrust the inmates entrusted to their care (Enders, 2004), inmates often perceive that correctional health care providers do not provide optimal care to meet their needs and view health care providers as just another arm of the prison system (Tillman, 2000). Elderly inmates are particularly suspicious of the care that they receive in prison (Granse, 2003). A study of older male state prison inmates indicated that inmates felt that, "prison health care professionals are unresponsive to their needs" (Loeb, Steffensmeier, & Myco, 2007, p. 327). Such perceptions could cause inmates, regardless of gender, to delay accessing needed health and EOL care in prison.

The most intensive health care is provided in the prison infirmary where expected deaths are most likely to occur. In this setting dying inmates are "removed from the general prison population and housed in conditions of social isolation, limited environmental stimulation, reduced privileges, scant recreational opportunities, and extraordinary control over their every movement" (Haney & Zimbardo, 2001, p. 31). Transfer to the infirmary during terminal decline creates barriers to whatever form of within-prison community support was established during long incarcerations. At best, the dying inmate may be placed in a reverse airflow isolation room to provide a modicum of privacy, but in many prisons, infirmary resources are very limited. Particularly in women's prisons that have exceeded estimated housing capacity, available infirmary space and equipment are inadequate. Intravenous and feeding tube pumps and fully functioning therapeutic beds are seldom available. Drugs are limited to a formulary that is much more restrictive than those to which acute or long-term care nurses are accustomed. If needed drugs are not stocked, no pharmacy is available for immediate delivery.

2. The time has come to provide end-of-life care to all dying female inmates.

Staffing patterns in the infirmary include high nurse-patient ratios that prevent even the most compassionate nurses from spending much time with dying patients. Further compounding the problem, security regulations restricting touch may cause nurses to be reluctant to engage in basic comforting actions such as laying a hand on the arm of a suffering person or giving a back rub. Some prisons have inmate “hospice” workers or volunteers who have been trained to provide comfort to the dying inmate and assistance to the nursing staff; however, for many, the notion of “hospice care” refers to sitting a death vigil. Inmate volunteers may not be permitted to attend to dying inmates during lock-down or other times of heightened security.

No routine visiting hours exist in prison infirmaries, and special dispensation from the highest echelons of the prison administration is typically required for a bedside visit by outside family. These visits require special security, and corrections officers are placed at the scene. Inmate peers from the housing cell block, some of whom have interacted with the dying inmate for decades, are not routinely among approved visitors to the infirmary. Much like family visitors, these inmates require special permission from shift commanders (i.e., the highest ranking Corrections Officer on a given shift) or higher level administrators to see their dying friends.

Facing one’s own mortality under the specter of dying in prison prompts many inmates to long for freedom so that they can die as a free person. Inmates particularly fear dying alone and in prison, which is viewed as the ultimate mark of failure in life (Moss-Coane, 1995). Legacy issues also figure prominently, for inmates are concerned that they will be remembered only for the wrongs that they have committed (Enders, 2004). Uncertainty is prominent in inmates’ fears regarding pain, disability, helplessness, and loss of whatever independence is retained in the highly restrictive environment of prison.

Prison life is marked by personal losses, such as the loss of personal identity, social roles, individuality, and the freedom to move. Interpersonal losses don’t stop during extended incarcerations, and family visitations, “can cause a continuous grief reaction with each visit” (Aday, 2003. p. 183). This results in some older female prisoners compartmentalizing and developing social distance from their families in order to cope (Aday, 2003). In addition, the family and friends of inmates living outside of prison may die while the inmate is serving a long sentence. Feelings of guilt for not being present with their dying loved ones and remorse for past life choices may make the loss particularly intense for female inmates.

Some prisons have explicit policies regarding death notification for outside deaths; for example, the chaplain may be designated to deliver the “bad news” of death notification following a prescribed process of verification. However, this humanistic approach is not universal. Enders (2004) shared the story of an inmate who was notified of the death of a family member through a note dropped into the inmate’s cell by a corrections officer during inmate count. The note simply stated, “Your mother died last night” (p. 619).

As friendship networks develop within prisons, a new source of potential loss emerges: inmate deaths. Inmates may witness the aftermath of an attempted or successful suicide on the housing unit. It is commonly noted that “there are no secrets in prisons,” and news of inmate deaths due to natural causes are communicated rapidly among the inmates via informal channels. Deaths in and outside of prison accumulate over the long course of incarceration that many women face. Grieving is often hidden or suppressed to avoid appearances of vulnerability, and as a result, unresolved grief builds. Beyond challenges and barriers inside the walls of prison, the issue of public sentiment also must be considered.

Granse (2003) reported that inmates’ need for improved EOL care has garnered little if any public sympathy; instead continued apathy to their suffering is common. In fact Cannon

(2001) described the public view that inmates are a group that should be left to rot. As recently as 2003, Granse reported, “in the United States, prisoners regularly die shackled to their beds, with little or no public response” (p. 366), although these researchers have seen no such situations in their research or fieldwork. However, Rierden (1997) aptly summarized sentiments that the authors have heard voiced many times:

I was stunned by comments people outside the prison system made to me either casually or in formal discussions about prisoners. I discovered on a number of occasions just how deeply entrenched are the myths and prejudices regarding incarcerated people. Even my mention of doing research in the prison was sometimes enough to trigger hostile remarks about “those people.” (p. xvi).

The inconsistent public view regarding provision of humane care to inmates through the EOL is related to naïve considerations of crime, sentencing, and punishment. Byock (2002) asserted that many people responded that humane and compassionate care for dying inmates “is the right thing to do” (p. 107), while an other responded that convicted criminals “deserve whatever they get. If they die suffering, in pain and alone, so be it” (Byock, 2002, p. 108). Negative sentiments are perpetuated by perceived inequities in the provision of health care. In *Estelle v. Gamble* 1976, “the U.S. Supreme Court held that prisoners had a constitutional right to health care” (Rold, 2006, p. 103). Many people do not understand that prison inmates are considered wards of the state entrusted to the penal system and entitled to basic medical care. Corrections employees who have experienced difficult, traumatic deaths of family members or unresolved grief tend to carry negative sentiments into the workplace. The provision of humane EOL care to “convicted criminals” is challenged when staff members believe that the dignity or comfort of their relatives—hard-working upstanding citizens—was not adequately addressed outside of prison.

Facilitating Change in a Complex System

Meeting the needs of female inmates at the end of their lives requires change for two groups: inmates and corrections nurses. First, inmate patients should be prepared and encouraged to take more active roles in their health, including EOL decision making. Provision of foundational health information in a clear and logical manner at a level that even those female inmates with limited literacy can comprehend is an essential undertaking for corrections nurses. Once armed with essential health knowledge, female inmates should be supported in informed decision making regarding medical treatment options and EOL care (Enders et al., 2005).

It is essential that corrections nurses not lose sight of their caring mission (Maeve, 1999), and tapping into community professional resources could prove to be a fruitful undertaking. Community agencies such as hospices can provide expertise in pain and symptom management and palliative care, and university settings, including schools of nursing, hold much potential for contributing to staff development and education for nurses. In addition, specialty, community-based hospice and palliative care organizations provide important information that corrections nurses can access through publications and websites. Finally, professional training through the End of Life Nursing Education Consortium (ELNEC) (2010) would be a cost effective investment of correctional health care administrators, since their train-the-trainer sessions could be attended by a small group of nurses and later shared with the broader group of corrections nurses through in-house staff development.

Beyond staff education and training, there are viable models for providing high quality EOL care to inmates. Several innovative hospice programs in U.S. prisons have emerged as exemplars of humane EOL care, balancing the competing demands for inmate confinement and public safety (Byock, 2002; Cahal, 2002). Programs arose for male inmates in

Vacaville, California (Linder, Knauf, Enders, & Meyers, 2002) and Springfield, Missouri correctional facilities in the late 1980s (Maull, 1998) and in Angola, Louisiana in 1998 (Evans, Herzog, & Tillman, 2002; Harrison, 2006). Angola prison offers programs that meet the National Hospice and Palliative Care Organization's standards and reportedly delivers them at no additional cost to the penitentiary. Care is provided by existing staff and inmate volunteers (Evans et al.).

Models do exist for improving EOL care in women's prisons. The Federal Medical Unit in Carswell, TX, a correctional facility incarcerating women from across the United States, served as one of the four demonstration sites for the Robert Wood Johnson funded Guiding Responsive Action in Corrections at End-of life (GRACE) Project. Initiatives undertaken at Carswell included the following: development of a syllabus outlining hospice issues that all new prison wardens would be educated on when hired into the Federal Bureau of Prisons; a telehealth conference to prepare federal prison staff to better work with inmates who become eligible for hospice services; and services to address the bereavement needs of both patients and families (Ratcliff & Craig, 2004).

The National Commission on Correctional Health Care (NCCHC), an organization that seeks to improve the quality of healthcare services in prisons, provides accreditation to institutions that meet or exceed their standards (NCCHC, 2008). The standard of care for terminally ill inmates (those with less than one year life expectancy) indicates the need for pain management, possibility of care in a community setting, staff training, and if a hospice program is present, informed choice by the inmate about hospice participation. The overarching goal is the achievement of a "good death" (NCCHC, p. 110) with adequate pain control, dignity, and a supportive community of family/friends. Unfortunately, this standard is designated as an important but not essential standard (NCCHC, p. 109).

Over the past decade, the science supporting EOL care has advanced considerably due in no small part to the focused attention of the National Institutes for Health, National Institute for Nursing Research. While the state of the science has advanced, infusion of best practices into complex organizations remains problematic. In comments regarding the GRACE project, Ratcliff (2000) noted that "end-of-life programs in prisons across the country will require more than a cookbook of resources" (pp. 509–511). One of the most difficult challenges for enhancing care for dying inmates is the rival goals of the prison system and the culture of healthcare.

The most powerful change agents in the bureaucratic, hierarchical organization of women's prisons are on the inside; they are the frontline workers who understand the balance between care and custody and control. Frontline correctional employees (e.g., nurses and physicians, mental health workers, chaplains, corrections officers, and administrative staff) know the system's needs, constraints, and barriers, and they know how to make things happen, both within and around policy. Armed with this understanding, the authors are engaging in participatory action research methods to infuse enhanced EOL care strategies into state corrections institutions (Loeb, Penrod, Hollenbeak, Smith, & Scharff, 2009).

Broader implementation and greater success in infusing EOL care into correctional settings will be actualized through the teaming of researchers with insider stakeholders to thoughtfully adapt research-based "free-world" strategies to meet the demands of the local prison communities. Infusion of EOL initiatives should enhance community relations and inmate morale stemming based on humane death experiences, minimized suffering, and demonstrated care and compassion within the prison environment. These factors are important to stakeholders, since "death and bereavement are universal, and compassion for the dying not only comforts them, but it also liberates the caregivers, who have or inevitably

will face the same issues” (Rold, 2002, p. 103). Generalist EOL strategies must be appropriate for implementation by non-specialists who typically care for patients with a wide array of conditions or concerns. These strategies can be delivered in the midst of standard care in a decentralized manner (Shipman et al., 2008). This approach is similar to the recommendation of The American Academy of Nursing’s Palliative and End-of-Life Care Expert Panel (2001) to integrate EOL skills into the care of people with acute and chronic illnesses. In the end, we contend that the application of generalist strategies can extend beyond healthcare providers, permeating multiple layers of personnel who interface with inmates to change the corrections community’s approaches to inmates at the EOL.

More specific recommendations include improving provider safety while enhancing nurse patient relationships, inmate legacy building activities, pain management during EOL, chaplain referrals, and grief support systems. Improving EOL care for female inmates needs to incorporate both safety and security. Within the prison system, caring interactions cannot supersede security even when caring for the dying, as custody and control remain paramount considerations. Compassion for dying inmate patients can be neither mandated nor legislated; however, legislative and correctional policies and the interpretation of them can aid or impede compassionate care (Beck, 1999).

CALLOUT 3

Nurse-patient relationships that are mutually trusting (Enders, 2004), honest, supportive, and therapeutic in nature are needed (Dubler, 1998). Blinding the health care professional to the reason for incarceration would facilitate a nonjudgmental attitude that avoids prejudice (Enders, 2004). A vigilant practice of universal precautions regarding safety and security practices with all inmate patients would decrease potential unsafe practices that may jeopardize provider safety. Regular and thorough pain assessments are essential and should include awareness of nonverbal cues such as fist clenching, frowning, moaning, and tightening of the facial muscles (Enders, 2004). Correctional nurses caring for dying female inmates need recognize that discomforts of dying in prison are not only limited to physical pain, but also extend to such feelings as helplessness, isolation, loneliness, and weakness (Zimmerman et al., 2002).

Legacy building activities may help female inmates with life-limiting illnesses to realize that their lives have counted for something instead of viewing themselves as life-long criminals who are hated by society (Enders 2004). Although no reports describe the institution of such an intervention within the prison setting, Allen et al. (2008) implemented a legacy activity with a sample of largely African American, Protestant, urban-dwellers from the southeastern United States. The three session intervention involved the following: discussing positive memories from the dying patient’s and caregiver’s shared past; determining a time period in the patient’s life that could be adequately represented in one legacy project (e.g., cookbook or scrapbook); coaching, reinforcing, and problem-solving with the dyad to promote progress toward creating tangible and lasting legacy materials; and finally, sharing of their legacy with the interventionist as well as family members and friends. Benefits experienced by the dying patients included decreased breathing difficulty; reduction in pain and depressive symptoms; increased talkativeness; and increased sense of religious meaning (Allen, Hilgeman, Ege, Shuster, & Burgio., 2008). Such an intervention easily could be undertaken by either registered nurses or advance practice nurses working in correctional settings. Legacy activities could provide female inmates with an opportunity to reconcile

3. Harnessing nurses’ expertise and applying their power of compassion may allow women prisoners to die with a modicum of dignity, respect, and humane care.

with estranged family members, for as Granse noted, it is “important to have an opportunity for atonement or forgiveness” (2003, p. 371).

The tendency of female inmates to form familial relationships in prison will likely serve as an important source of nurturing and support for the dying women. Nurses have long had an interest in caring not only for their patients, but also for their patients’ family members. In the prison setting, this mission can be achieved by advocating for more liberal visitation from family members outside of prison and being supportive of opportunities for dying inmates to visit with any incarcerated family members through face-to-face, teleconferenced, or telephone communication. Such communications are important as inmates approach their end of life. Not all inmates have families who are willing, available, and able to visit them, and inmate peers could be a viable substitute for many women. The opportunity for well inmates to care for their dying peers can provide transformative experiences that help them to create new legacies. Inmate volunteers can and are trained by nurses to provide a comfortable environment, console dying inmates, raise funds for special food or sundry items, read, or sit vigil. This opportunity allows the inmate volunteers/buddies to affirm their humanity and holds promise for changing the culture of the prison institution (Enders, 2004).

Nurses are in the position to initiate chaplain referrals especially for inmates whose family members are unwilling to come and reconcile with them. The focus of this meeting should not be to coerce the woman to find religion. The chaplain should be a supportive presence if the inmate desires counsel prior to death (Enders, 2004).

Inmates need an opportunity to grieve the loss of a member of their communities. Readings, memorial services, and candle lighting are relatively low-cost ways to remember the deceased and acknowledge grief. Realizing that people grieve differently, one woman, “may prefer to engage in physical activity rather than talk about her feelings” (Olson, 2004, p. 227), whereas others may prefer grieving groups for sharing thoughts and feelings (Winterowd, Morgan & Ferrell, 2001). Making quilts or other gestures of remembrance also can be helpful (Enders, 2004).

Conclusions

Within the current, prevalent public climate of “let ‘em rot,” incarcerated women with EOL needs are highly vulnerable. Changing the complex organization of prisons is not easy, instead it is achieved by grooming champions from inside the system and providing them with best practices that can be adapted to fit the system demands of prisons. Their focus would ideally remain steadfast on the following goal: “to improve quality of life through the journey of death for terminally ill inmates” (Enders, 2004, p. 623). It is time to harness nurses’ expertise and apply their power of compassion to allow women who have served their sentences to die with a modicum of dignity, respect, and humane care. Ferrell and Coyle (2008) noted, “Nurses are the constant presence for patients and families....across all settings of care. Individuals look to the face of a nurse for reassurance, understanding, and as a human connection in the overwhelming reality of health care” (p. 14). The time has come to set aside the question “why provide humane care to dying female inmates?” and to provide better EOL to *all* people.

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Table 1

Overview of Prison Security Levels

Level	Security features include but are not limited to the following:
Minimum	Housing may be dormitory style, cubicles, or rooms Line of demarcation if 200 beds or less, single security fence if larger than 200 beds
Medium	Housing in single, double, or multiple occupancy cells Double fence (14 feet in height) with razor ribbon at the top of each and a total 4 rolls at the bottom of exterior fence Intrusion and fence detection systems A mobile perimeter patrol
Close	Housing in single or double cells Double fence (14 feet in height) with razor ribbon at the top of each and a total of 6 rolls at the bottom of exterior fence Intrusion and fence detection systems Perimeter towers or perimeter wall with towers Two perimeter patrols or a single patrol and a perimeter tower
Maximum	Single cells with secure control booth with remote electronic locking capabilities Cells doors with food passes (e.g., ability to pass food tray to inmate without opening cell door) Perimeter same as in close security facilities

(R. Ellers, personal communication, January 18, 2011).